THE SUQUAMISH TRIBE

SUQUAMISH HEALING HOUSE MEDICAL CLINIC

New Patient Registration Form

Today's date:	

PATIENT INFORMATION

Legal name as it appears on your social security card:				Preferred Name:
Last name: First: Middle:				Pronouns:
Former/Maiden name:	DOB:	Age:	Sex at birth ☐ M ☐ F	Gender ☐ M ☐ F ☐ Another Gender
SSN:	Primary phone #:			Alternate phone #:
Permission to contact me for appointment reminders: ☐ YES ☐ NO Permission to leave voice mail message on phone number(s) above: ☐ YES ☐ NO				Marital status (check one) ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Physical address:	Mailing address (if different)
County:	Email:
Employer:	Occupation:

Race (Check all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White ☐ Other Pacific Islander ☐ Other

IHS ELIGIBILITY

☐ **Tribal Enrollment #:**_____

☐ **Tribal Affiliation**:_____

☐ **Not Applicable, not Native American**

☐ **Enrolled Descendant of Tribal Member**

Please provide documentation of your Tribal status. Acceptable documentation for Enrolled Descendants include: Certificate of Indian Blood, Birth Certificates, etc.

If <18 years old
Parent or guardian name: _____ Phone Number:_____.

Parent or guardian name: _____ Phone Number:_____.

Legal guardian name/agency: _____ Phone Number:_____.

Did you retire from the Military? ☐ Yes ☐ No	Are you eligible for Tricare benefits? ☐ Yes ☐ No
Do you have any unpaid Medical Bills? ☐ Yes ☐ No	☐ Hispanic ☐ Non-hispanic

EMERGENCY CONTACT

Name of local friend or relative:	Relationship to Patient:
Phone Number:	Alternate phone number:

Release medical information to this individual: ☐ YES ☐ NO

PREVIOUS PHYSICIAN OR PRIMARY CARE CLINIC

Clinic name:	Physician name:

PREFERRED PHARMACY

Pharmacy:	**City:**

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INSURANCE INFORMATION	
TRIBAL MEMBERS: Do you have any other (not tribe provided) Medical Insurance? ☐ Yes ☐ No If no, have you applied for Apple Health? ☐ Yes ☐ No If yes, Date Applied:	**Please provide your insurance card(s).**
Do you have Medicare? ☐ Yes ☐ No If yes, Medicare ID: _____ Part D Carrier: Part D ID#:	Are you currently employed? ☐ Yes ☐ No If yes, are you enrolled in employer medical insurance? ☐ Yes ☐ No

Primary Medical Insurance Carrier Name:		
ID#	Group#	Effective Date:
Subscriber's name:	DOB	☐ Self ☐ Spouse ☐ Child ☐ Other
Secondary Medical Insurance Carrier Name:		
ID#	Group#	Effective Date:
Subscriber's name:	DOB	☐ Self ☐ Spouse ☐ Child ☐ Other

ATTESTATION

The above information is true to the best of my knowledge.

_____.
Patient Name

_____ _____
Patient/Parent/Guardia/Legal Representative signature Date

_____. _____.
Patient, if >13 years old (applies to certain medical conditions) Date

For Office Use Only:

Entered into EMR:_____ Date: _____

Reviewed: _____ Date: _____

STHH

Revised 21JUN2024