Eastern Aleutian Tribes
PATIENT REGISTRATION

EAT CHART NUMBER:	1) Patient Demographic	ANMC CHART NUMBER:

Legal Last, First, MI:

Gender: ☐Male ☐Female	Birth Date:	SSN:
Place of Birth:	Maiden Name:	
Marital Status: ☐Divorced ☐ Married ☐Separated ☐ Single ☐Widowed		
Address:	City:	State: Zip:
Home Phone:	Work Phone:	Email:
Local Home Address:	City, State, Zip:	
Date arrived in community:	Religious Preference:	

2) Alaska Native/American Indian Information

☐ Yes, please continue on below ☐ No, continue on to section 3

Tribal/Native Corporation: Tribal Enrollment #:

Blood Quantum: ☐1/8 ☐1/4 ☐1/2 ☐3/4 ☐Full ☐Other:

3) Guarantor

Responsible Person (Guarantor): Relationship to Patient:

Address: City State: Zip:

4) Employment Information

Employment Status: Active Military Duty ☐Disabled ☐Full-Time ☐Part-Time ☐Retired ☐Self-Employed ☐Unemployed

Employer:	Phone Number:
Address:	City, State, Zip:

5) Emergency Contact Information (Must Complete)

Emergency Contact:	Relationship:
Address:	
City, State, Zip:	Home Phone:

6) Next of Kin Information (Must Complete)

Next of Kin:	Relationship:
Address:	
City, State, Zip:	Home Phone:

7) Insurance Information (Must Complete)

Medicare: ☐ Yes ☐ No Medicaid: ☐ Yes ☐ No Private Insurance: ☐ Yes ☐ No

Policy Holder:	Relationship:	SSN:
Policy Holder DOB:	☐Male ☐Female	Employer:
Address:	Phone:	Effective Date:

8) Veteran Information

Veteran: ☐Yes ☐No		Service Branch:
Entry Date:	Exit Date:	Vietnam Service Indicated? ☐Yes ☐No

9) Household Information (Must Complete)

Are you Hispanic or Latino: ☐Yes ☐No ☐Unknown ***If you check here check race below***

☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian ☐Other Pacific Islander ☐White ☐ More than one race ☐Unknown

Is your Primary Language English?: ☐ English ☐ Other_____

Preferred Language if not English: ☐Japanese ☐Korean ☐Russian ☐Spanish ☐Tagalog ☐Other:_____

Migrant Worker? ☐Yes ☐No Homeless: ☐Yes ☐No

Internet Access: Yes ☐No ☐Home ☐Healthcare Facility ☐Library ☐School ☐Work ☐Tribal/Community Center

Generic Health Permission: ☐Yes ☐No Preferred Method: Phone, Email or Mail Email Address:

Number in Household: **Annual Household Income:**

I validate that all information stated in this document is accurate to my best knowledge.

Signature: _____ Date: _____

1. Update Initials: _____ Date_____ **2.** Update Initials: _____ Date_____ **3.** Update Initials: _____ Date_____

Eastern Aleutian Tribes

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION TO INSURANCE

1. CONSENT FOR TREATMENT (initials_____)

I, _____, consent to the examination and procedures which may be performed during this village clinic visit, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examinations, medical treatment or procedures, rendered to me as the patient or to _____as his/her legal guardian under the general and special instructions of the patient's health aide(s), physicians(s), or practitioner(s).

2. ASSIGNMENT OF MEDICAL INSURANCE BENEFIT (initials_____)

I assign Eastern Aleutian Tribes (EAT), and the health aide, attending providers and consulting physicians, radiologists, and pathologists, performing duties at the village clinic hereafter referred to as "providers" all benefits now due and to become due and payable to me under medical insurance policies, by virtue of my village clinic treatment, to EAT. I direct my medical insurance or payors to pay such benefits directly to the providers in consideration of medical care and services furnished by the providers. The insurance company is authorized to deduct payments from its obligations to me for medical benefits provided under my policy. I certify the information given by me in applying for payments under Title XVIII of the Social Security Act is correct. I understand that I remain financially responsible to the providers for charges not met by the proceeds of this assignment. Medicare, government agencies and insurance companies may not pay for treatment they identify as maintenance or custodial care.

3. AUTHORIZATION TO RELEASE INFORMATION FOR BILLING PURPOSES (initials_____)

I authorize EAT to disclose medical information, i.e. diagnosis, discharge summary, doctors' orders, progress notes and other related documents to the extent required to assure payment to any agency which is liable under a contract including benefits assigned by Title XVIII of the Social Security Act. This would include any drug, alcohol, mental health diagnosis and/or treatment, (Federal Regulation 42CFR, Pt. 2) or HIV "AIDS" diagnosis or treatment that I may receive during the course of this treatment/admission.

4. PRIVACY ACT (initials_____)

I have received the Notice of Privacy Practices. I have been informed that my record is or will be kept in the Health and Medical Record System(s) at EAT. I understand that the information given by me and/or collected and stored in my health record is necessary for Indian Health Service staff or IHS contractors to provide service for my health and well-being. Furthermore, I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person, unless specified as routine use, without my signed consent.

5. ADVANCE DIRECTIVES (initials_____)

I have Advance Directives, also known as living will, durable power of attorney, Do Not Resuscitate order, etc.

☐ Yes ☐ No ☐ Patient younger than 18 years ☐ Unable to assess

Reason:_____

If yes, I have provided a copy of any of the above documents to the village clinic, Alaska Native Medical Center, or South Central Foundation. ☐ Yes ☐ No

If no, would you like additional information regarding Advance Directives? ☐ Yes ☐ No

This authorization is valid until account is paid, upon my election to terminate the contract, or one year from date of signing. Any termination must be in writing.

_____ _____

Signature of Patient/Legal Guardian If other than patient, indicate relationship

_____ _____

Witness Date

1. Update Initials: _____ Date_____ **2.** Update Initials: _____ Date_____ **3.** Update Initials: _____Date____