****For Office Use Only*****

Eligibility Status: **Ineligible Patient-Employee Health Only**

Chart # _____

The Tulalip Tribes

Patient Registration

SECTION A PATIENT DEMOGRAPHIC INFORMATION

Patient Name: [LAST] [FIRST] [MIDDLE] Mark if Applicable ◯ Sr. ◯ Jr. ◯ II ◯ III					Patient Sex: ☐ MALE ☐ FEMALE
Other Names Used:	Date of Birth:	Place of Birth:			Social Security#
Address:	City:		State:	Zip Code:	County:
How long at current address?	Mailing Address: (if different from above)		Is this on a Reservation? ☐ Yes ☐ No If yes, which Reservation?		Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Significant Other
Home Phone#: Primary #? ☐ Yes ☐ No	Cell #: Primary #? ☐ Yes ☐ No				

SECTION B EMPLOYMENT INFORMATION

Where are you employed:	Occupation:		
Employer Name:	How long with employer?	Work Phone#	
Address:	City:	State:	Zip Code:

SECTION C OTHER PATIENT INFORMATION

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic/Latino ☐ Unknown by Patient ☐ Declined to Answer

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ African American ☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Unknown by Patient

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Does the patient have internet access? ☐ Yes ☐ No

Where?

☐ Home ☐ Work ☐ School ☐ Health Care Facility ☐ Library ☐ Tribe/Community Center ☐ Mobile Device

Patients Email Address: _____

☐ Home ☐ Work ☐ School ☐ Health Care Facility ☐ Library ☐ Tribe/Community Center ☐ Mobile Device

Do we have permission to send generic health information to your email address? ☐ Yes ☐ No

What is your preferred method to receive reminders? ☐ Phone ☐ Mail ☐ Email

SECTION D CONTACT INFORMATION

Person who can be contacted in the event of an emergency:

Name:	Relationship:		Phone#
Address:	City:	State:	Zip Code:

SECTION E ALTERNATE RESOURCE INFORMATION

PRIVATE INSURANCE

Private Insurance Plan Name:	Policy Number	Group Number

SECTION F Privacy Notice and Other Information

Health Insurance Portability and Accountability Act (HIPAA) of April 14, 2003

Privacy Notice: How we will use or disclose your private health information:

Treatment Payment Public health/law required

Operations (healthcare business) Appointments/reminders

Business associates who provide services or support by contractual agreement

You have the right to request a restriction of disclosure of above. Requests must be submitted in writing for review. If restriction is not granted we are required to give you a written response

_____ _____

Signature Date