Tuolumne Me-Wuk Indian Health Center

Name: _____
DOB: _____

Patient Packet

Service: ☐Primary Care ☐Dental ☐Behavioral Health ☐Physical Therapy

Patient/Client Information: □ New □ Update

Last Name:_____ First Name:_____ M.I.: _____

Mailing Address:_____APT #: _____

City/State/Zip: _____

Home Phone:_____Cell Phone:_____Work Phone: _____

Preferred method of contact: □ Cell phone □ Email _____

Marital Status:_____Date of Birth:_____Social Security: _____ Gender: _____

Sex assigned at birth:___Veteran:_____Race:_____ Preferred Language:_____

_____Religion:_____Advance Directive: □Yes □ No **How did you hear about us**: Referral: □Friend □ Family □ Advertisement □ Social Media Other: _____ By supplying us with your contact information you agree to opt into our appointment reminder system. □Yes □ No

Emergency Contact Information:

Emergency Contact Name: _____

Emergency Contact Phone #:_____Relationship:_____

Employer Information:

Employer Name and Address: _____

Phone Number:_____Occupation: _____

Tribal Information (if applicable):

Tribe of Membership: _____

Tribe of Membership address: _____

Reservation residing on:_____

Member of Indian Household:_____Relationship:_____

Degree of Blood:_____Enrollment Number: _____

Official Use Only: □ Forwarded to PRC DATE:_____PSR Initials: _____

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Insurance Information

Insurance: Responsible Party – If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

□ Parent of minor □ Guardian of minor

Guarantor: _____ Date: _____

□ Same address Different address: _____

	Primary Medical Insurance:	Secondary Medical Insurance:
Insurance company name:	_____	_____
Policy Holder Name:	_____	_____
Policy Holder's Date of Birth:	_____	_____
Member ID #:	_____	_____
Patient Relationship to Policy Holder:	_____	_____

Please read and check each of the following statements

□ **AUTHORIZATION TO RELEASE INFORMATION FOR BILLING PURPOSES AND PAYMENT OF BENEFITS TO TMWIHC**: I hereby authorize the release of any information including diagnosis of a medical condition for the sole purpose of submission to Third Party billing insurance carriers, and that the statements above are true and correct to the best of my knowledge. I understand that if all insurance information is not complete or correct, I may be responsible for services rendered. I further authorize payment of all service benefits to TMWIHC.

□ Telehealth Consent: I consent to engage in telehealth with TMWIHC medical, dental, and behavioral health.
□ I have received a copy of my Notice of Privacy Practice and Rights and Responsibilities.

I give permission for:

_____ □ To bring my child to the doctor □ To receive Medical information □ financial information

_____ □ To bring my child to the doctor □ To receive Medical information □ financial information

Signature of Responsible Party: _____ Date: _____

Other: _____

Official Use Only: PSR Name: _____ Date: _____