Peter Christensen Health Center
129 Old Abe Road
Lac du Flambeau, WI 54538
TEL: (715) 588-3371
FAX: (715) 588-2031

New Patient Registration and/or CHS update Form

Chart#_____

CONFIDENTIAL INFORMATION

Welcome to the Peter Christensen Health Center! Please fill out this form completely. If you have any questions or concerns, please do not hesitate to ask for assistance, we will be happy to help!

PATIENT INFORMATION:

Patient Name (Last, First, Middle): _____
Maiden/other names used: _____ Sex: ☐Male ☐Female
Race_____
Date of Birth: _____ Social Security Number: _____
Marital Status (circle one): M S W D Spouse Name: _____
Mailing Address: _____City: _____State: ____Zip: _____
Street Address (if different): _____
Date Moved to this address_____ Phone #: _____Cell #: _____
Work #: _____
Employer Name: _____ Employer Address: _____
Employment Status (circle one): Full-Time Part-Time Unemployed

Tribe of Membership (You must provide proof):_____
Enrollment Number:_____
If not enrolled, then living descendant of which tribe? (You must provide written proof)_____

Do you have any children under the age of 18? ☐Yes ☐No

Are you a Veteran? ☐Yes ☐No

Who can we contact in case of an emergency?

Name: _____
Relationship: _____Address: _____
Phone: _____

Name of Nearest Relative: _____ Relationship: _____
Address: _____ Phone: _____

Initials_____

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PARENTAL/Legal Guardian INFORMATION: (Only if patient is under 18)
Father's Full Name: _____
Mother's Full Maiden Name: _____
Other Legal Guardian: _____

PRIMARY PROVIDER NAME: _____
Do you need records transferred from another health care facility? ☐Yes ☐No If yes, please **completely** fill out a Release of Information form, available at the front desk.

INSURANCE INFORMATION: (PLEASE PROVIDE INSURANCE CARDS TO PATIENT REGISTRATION TO BE COPIED AND FILED)

PRIMARY INSURANCE INFORMATION:
Insurance Company Name: _____
Address: _____
Phone #: _____
Policy Number: _____ Plan Coverage: ☐Family ☐Single
☐Group #:_____
What does the plan cover? (Circle all that apply): Medical/Dental/Vision/Rx/Mental Health
Effective Date: _____ Policy Holder's Name: _____
Address of Policy Holder: _____Phone #: _____
Relationship to Patient: _____
Policy Holder's SS#: _____ DOB: _____ Sex: ☐Male ☐Female
Medicaid Number: _____Effective Date: _____
Medicare Number: _____ ☐A Only ☐B Only ☐A & B Eligible
Medicare A effective date: _____ Medicare B effective date: _____

SECONDARY INSURANCE INFORMATION:
Insurance Company Name: _____
Address: _____
Phone #: _____
Policy Number: _____Plan Coverage: ☐Family ☐Single ☐Group #: _____
What does the plan cover? (Circle all that apply): Medical/Dental/Vision/Rx/Mental Health
Effective Date: _____Policy Holder's Name: _____
Address of Policy Holder: _____Phone #:_____
Relationship to Patient: _____
Policy Holder's SS#: _____DOB: _____ Sex: ☐Male ☐Female

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Authorization to furnish information and Assignment of benefits (Private Insurance, Medicare, and Medicaid)

The Peter Christensen Health Center may disclose all or any part of the patient's health record to any person or corporation which is or may be liable under a contract to a hospital, medical service company, insurance company, workers compensation, public aid funds, patient's employer, Medicare, Medicaid, IHS, etc.

I hereby assign to the Peter Christensen Health Center such benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me or dependants included in my insurance policy. I **AUTHORIZE** payment of such benefits to the Peter Christensen Health Center. I understand this assignment will remain in effect until revoked by me in writing. A scanned copy of this assignment is to be considered as valid as the original.

Patient Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

My signature on this form acknowledges that I have received a copy of Peter Christensen Health Center's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by PCHC and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Patient Name (printed): _____ Date of Birth:_____

Patient Signature: _____ Date: _____

_____

Signature of Patient Representative (State relationship to Patient) Date
Or Witness (if signature is by thumb print or mark)

_____ _____ _____

Signature of PCHC staff member Title Date

TO BE COMPLETED BY PCHC EMPLOYEE IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of PCHC Notice of Privacy Practices? ☐Yes ☐No
2. Briefly describe efforts made to obtain the patient's acknowledgement of receipt of the Notice and explain why the patient was not able or willing to sign this form: _____

_____

_____

_____ _____ _____

Signature of PCHC staff member Title Date

Initials_____