# PATIENT REGISTRATION FORM

Indian Health Board of Minneapolis, Inc.

TOP OF LABEL HERE

## PATIENT INFORMATION:

**First name:** **Middle name:**

**Last name:**

**I prefer to be called:** **Date of birth:** ___ ___ /___ ___ /___ ___ ___ ___

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

**Street Address:** **Apt#:** ☐ Primary ☐ Alternate

**City:** **State:** **ZIP code:**

**Primary phone:** ☐ Home ☐ Cell **County:**

**Preferred contact method:** Phone call ☐ Home ☐ Cell ☐ Secure Message (Patient Portal) ☐ Postal Letter **E-mail:** _____

**Social Security number:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **Sex at birth:** ☐ Male ☐ Female

**Primary language:** ☐ English ☐ Spanish ☐ Other: _____

**Race:**
☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Two or more races
☐ American Indian and Alaska Native

**Ethnicity:**
☐ Hispanic or Latino
☐ NOT Hispanic or Latino

**How did you hear about our clinic?**
☐ Brochure ☐ Website
☐ Facebook ☐ The Circle News
☐ Current Patient
☐ IHB employee
☐ IHB medical provider
☐ MNsure

**Tribal Enrollment:** ☐ Yes ☐ No ☐ Self Certification **Tribal Affiliation:** _____

## GUARANTOR INFORMATION ☐ Same as patient ☐ Guarantor is other ☐ No guarantor is selected

**Name of Guarantor:** **Date of birth:** ___ ___ /___ ___ /___ ___ ___ ___

**Relationship:**

**Guarantor Address:**

**Guarantor Phone:** ☐ Home ☐ Cell ☐ Work

| | | |
|---|---|---|
| **MEDICAL INSURANCE** | **Primary:** | **Secondary:** |
| **DENTAL INSURANCE:** | | |

## PHARMACY INFORMATION

**Pharmacy:** **Phone:**

**Pharmacy address:**

## DEMOGRAPHIC INFORMATION ☑ Check all that apply

| **Country of origin:** | **U.S. citizenship:** ☐ Yes ☐ No | **Military veteran:** ☐ Yes ☐ No | **Interpreter, needed?** ☐ Yes ☐ No |
|---|---|---|---|

**Sexual orientation:**
☐ Lesbian Or Gay
☐ Straight (NOT gay or lesbian)
☐ Bisexual
☐ Something Else
☐ I Do Not Know
☐ Choose Not to Disclose

**Gender:**
☐ Male
☐ Female
☐ Other
☐ Female to Male Transgender
☐ Male to Female Transgender
☐ Choose Not to Disclose

**Emergency Contact:** **Relationship:**

**Emergency Phone:** ☐ Home ☐ Cell ☐ Work

Any changes to this form must be reviewed and approved by Health Information Management



Version 1/2019

**INCOME VERIFICATION** ☐ Check one box that describes the total monthly income based on family size

| 1 person family | 3 persons in family | 5 persons in family | 7 persons in family |
|---|---|---|---|
| ☐ less than $1,012 | ☐ less than $1,732 | ☐ less than $2,452 | ☐ less than $3,172 |
| ☐ $1,013 to $1,265 | ☐ $1,733 to $2,165 | ☐ $2,453 to $3,065 | ☐ $3,173 to $3,965 |
| ☐ $1,266 to $1,518 | ☐ $2,166 to $2,598 | ☐ $3,066 to $3,678 | ☐ $3,966 to $4,758 |
| ☐ $1,519 to $1,770 | ☐ $2,599 to $3,030 | ☐ $3,679 to $4,290 | ☐ $4,759 to $5,550 |
| ☐ $1,771 to $2,023 | ☐ $3,031 to $3,463 | ☐ $4,291 to $4,903 | ☐ $5,551 to $6,343 |
| ☐ more than $2,024 | ☐ more than $3,464 | ☐ more than $4,904 | ☐ more than $6,344 |
| **2 persons family** | **4 persons in family** | **6 persons in family** | **8 persons in family** |
| ☐ less than $1,372 | ☐ less than $2,092 | ☐ less than $2,812 | ☐ less than $3,532 |
| ☐ $1,373 to $1,715 | ☐ $2,093 to $2,615 | ☐ $2,813 to $3,515 | ☐ $3,533 to $4,415 |
| ☐ $1,716 to $2,058 | ☐ $2,616 to $3,138 | ☐ $3,516 to $4,218 | ☐ $4,416 to $5,298 |
| ☐ $2,059 to $2,400 | ☐ $3,139 to $3,660 | ☐ $4,219 to $4,920 | ☐ $5,299 to $6,180 |
| ☐ $2,401 to $2,743 | ☐ $3,661 to $4,183 | ☐ $4,921 to $5,623 | ☐ $6,181 to $7,063 |
| ☐ more than $2,744 | ☐ more than $4,184 | ☐ more than $5,624 | ☐ more than $7,064 |

## GENERAL CONSENT

I hereby consent to treatment by the Indian Health Board of Minneapolis, Inc. (IHB). I assign, transfer, and set over to IHB my rights, title, and interest to my medical reimbursement benefit under my insurance policy.
I understand that I am financially responsible for all charges whether covered by insurance.

I authorize IHB to view my prescription history when providing evaluation or treatment services to me.
I authorize the exchange/ release of or access to any information, via paper or electronic review by IHB with any providers, hospitals and / or specialist(s) from whom I may receive care, or to wherever I may be referred for care, to coordinate my care, and to get complete and up-to-date information to each of the providers who treat me or to my insurance company to determine benefits and secure payment for services provided to me. I also authorize my other health care providers to release my information to IHB for these purposes.

I consent to the IHB contacting me via phone calls, email text message or through the patient portal for the purposes of appointment reminders, clinic updates, or information about the services provided by IHB.

## HEALTH DATA EXCHANGE

I authorize and consent to the release of or access to my health information, either in paper or electronic form, by IHB, my other health care providers, my insurer, health plan or claims administrator for care coordination and quality improvement purposes. This includes sharing my health information from treatment I have received at health care providers not related to IHB. My insurer, health plan or claims administrator may also share the above information with a care system or accountable care organization in which IHB participates. If I do not want my health information shared, I can opt out of participation by completing the Health Information Exchange Opt Out Form.

Minnesota law requires us to inform you that your medical records, no matter when created may be released for the purpose of medical or scientific research unless a written objection is received.

## NOTICE OF PRIVACY PRACTICES

I acknowledge that I was given/offered the notice of privacy practices today, or at a previous visit.

This authorization will continue unless I cancel by giving written notice to: IHB Attn: Health Information Management at 1315 East 24th Street, Minneapolis, MN 55404 or it expires as required by law.

**Print name of Patient –OR- Patient Representative:**

**Signature of Patient –OR- Patient Representative:**

**If you are a Patient Representative, state relationship to Patient:**

**Date:**