YELLOWHAWK TRIBAL HEALTH CENTER

ELIGIBILITY DEPARTMENT - PATIENT REGISTRATION FORM
46314 TIMINE WAY, PENDLETON, OR 97801 PHONE:
541-966-9830 FAX: 541-240-8760

UPDATED 06/01/2020

PATIENT'S FULL LEGAL NAME:

SEX: **DATE OF BIRTH:** **SOCIAL SECURITY NUMBER:** **CHART NUMBER:**

INDIAN OR NON-INDIAN: **TRIBE OF MEMBERSHIP:** **ENROLLMENT #:**

INDIAN BLOOD QUANTUM **TRIBE BLOOD QUANTUM** **OTHER TRIBE:**

PRESENT COMMUNITY **DATE MOVED TO COMMUNITY** ELIGIBILITY STATUS

MARITAL STATUS **CITY/STATE OF BIRTH** **EMAIL**

STREET ADDRESS: **PHONE:** **ALIAS**

EMPLOYER: **WORK PHONE:** **PART-TIME/FULL-TIME** ☐ ☐

MEDICARE/ID MEDICAID/ID RAILROAD RETIREMENT/ID

PRIVATE INS/ID/GROUP # ***Please provide a copy of all current insurance cards*** RELIGIOUS PREFERENCE:

FATHER'S NAME: FATHER'S CITY & STATE OF BIRTH: FATHER'S EMPLOYER

MOTHER'S MAIDEN NAME: MOTHER'S CITY & STATE OF BIRTH: MOTHER'S EMPLOYER

EMERGENCY CONTACT: PHONE: ADDRESS: RELATIONSHIP:

NEXT OF KIN: PHONE: ADDRESS: RELATIONSHIP:

HAVE YOU EVER SERVED IN THE ARMED FORCES? (Select) ENTRY/EXIT DATE: VIETNAM: (Select) VA CARD:

ETHNICITY: RACE: NUMBER IN HOUSEHOLD:

- I CERTIFY THE ABOVE INFORMATION TO BE ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE YELLOWHAWK TRIBAL HEALTH CENTER TO VERIFY THE ACCURACY OF THIS APPLICATION.
- I REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO YELLOWHAWK TRIBAL HEALTH CENTER FOR SERVICES FURNISHED TO ME BY YELLOWHAWK PROVIDERS
- I AUTHORIZE YELLOWHAWK TRIBAL HEALTH CENTER AND YELLOWHAWK PROVIDERS TO RELEASE ANY MEDICAL INFORMATION NECESSARY FOR DIAGNOSIS AND FURTHER TREATMENT, OR OTHER INFORMATION TO PROCESS THIS CLAIM(S).

APPLICANT'S SIGNATURE DATE

OFFICE USE ONLY **ELIGIBILITY DEPARTMENT**

RECEIVED BY:_____DATE:_____ ENTERED BY:_____DATE:_____ ELIGIBILITY:_____DATE:_____