HRN:	

## NEWBORN PATIENT CHECKLIST

Please bring the following original documents with your completed application.

$ \Box\operatorname{Proof}\operatorname{of}\operatorname{Birth}$
$\Box$ Discharge Forms
□ Insurance Cards
$\hfill\square$ Mothers valid Drivers license/valid government issued photo ID
□ Mothers Valid Tribal ID
□ Fathers valid Drivers License/valid government issued photo ID
□ Fathers Valid Tribal ID
(Unwed parents) notarized Declaration of Paternity
*New Born applications will be accepted within 60 days from birth.

HRN:		
111/11		

REGISTRATION CLERK'S INITIAL'S

## PUEBLO OF ISLETA – ISLETA HEALTH CENTER 1 Sage Brush Street – P.O. Box 580 – Isleta, New Mexico 87022 PATIENT REGISTRATION FORM

PATIENT NAME:	LAST	FIRST	MI	D.	ATE OF BIRTH	
CITY OF BIRTH	SEX	SOCIAL SE	ECURITY #	C	URRENT COMMUNITY	
MAILING ADDRESS		MAILING CITY		STATE	ZIP CODE	
PHYSICAL ADDRES	S	PHYSICAL CITY		STATE	ZIP CODE	
HOME PHONE		OFFICE PHONE	OFFICE PHONE		CELL/MESSAGE PHONE	
TRIBE OF MEMBER	SHIP	CIB/TRIBA	L ENROLLMENT NO	).	OTHER TRIBE	
RELIGIOUS PREFE	RENCE	ARE YOU	A VETERAN? YI	ES NO		
FATHER'S NAME	CITY, STATE OF BIRTI	H MOTHER	'S MAIDEN NAME (	CITY, STATE C	OF BIRTH	
EMPLOYER'S NAM	E					
SPOUSE EMPLOYER						
FATHER'S EMPLOY MOTHER'S EMPLOY						
EMERGENCY CONT	CACT NAME		PHONE #		RELATIONSHIP	
STREET ADDRESS		CITY	STA	TE	ZIP CODE	
NEXT OF KIN NAM	<u> </u>		PHONE #		RELATIONSHIP	
STREET ADDRESS		CITY	STA	TE	ZIP CODE	
PRIMARY INSURA	NCE INFORMATION		SECONDARY INSU	RANCE INFO	RMATION	
INSURANCE NAME			INSURANCE NAME			
POLICYHOLDER NA	AME		POLICYHOLDER NA	AME		
ID#	GROUP#		ID#		GROUP#	
DENTAL INSURANCE Vision Insurance	CE NAME & ID NUMBE		Behavioral Health			
	NY MEDICAL/DENTAL	NDERSIGNED, HERE	BY AUTHORIZE PAY		R MY MEDICAL/DENTAL PAID DIRECTLY TO THE	
SIGNATURE			<b>D</b> .	ATE		
<u>CENTER</u> TO PROV PHYSICIAN/DENTIS	IDE SERVICES AND	ADMINISTER PHYS OR EXPLAINING MED	SICIAN/DENTIST OR DICAL/DENTAL DIAC	DERS. I UN	BLO OF ISLETA, HEALTH NDERSTAND THAT THE TREATMENT TO ME AND	
SIGNATURE			<b>D</b> .	ATE		
ACKNOWLEDGEM	ENT OF RECEIPT	OF NOTICE OF P	RIVACY PRACTICI	E: L THE L	JNDERSIGNED, HEREBY	
	ECEIPT OF THE <u>PUEBL</u>					
SIGNATURE				ATE		

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RESPONSBILITY TO PROVIDE THE <u>PUEBLO OF ISLETA, HE</u> EVIDENCE OF MY INDIAN BLOOD/DESCENT <u>Initial</u> CERTIFICATE OF INDIAN BLOOD O <u>Initial</u> BIRTH CERTIFICATE (FOR CHILDRE I UNDERSTAND THAT FAILURE TO PROVIDE PROOF OF	ENTS: I, THE UNDERSIGNED, HEREBY ACKNOWLEDGE ALTH CENTER A COPY OF THE FOLLOWING DOCUMENT(S) AS IR OTHER TRIBAL ENROLLMENT IDENTIFCATION, EN NOT RECOGNIZED ON A TRIBAL REGISTRY) ELIGIBILITY WITHIN 60-DAYS MAY RESULT IN IMMEDIATE OF THAT I MAY BE BILLED FOR ANY SERVICES PREVIOULSY
SIGNATURE	DATE
FOR OFFIC	CE USE ONLY
We attempted to obtain written acknowledgement of acknowledgement could not be obtained because:	f receipt of our Notice of Privacy Practice, but
Individual refused to sign Communication barriers prohibited	d obtaining the acknowledgement
An Emergency situation prevented	l us from obtaining acknowledgement
Other (Please Specify)	
IHC EMPLOYEE SIGNATURE	DATE
PT REG REVISED 7/2021	REGISTRATION CLERK'S INITIAL'S

HRN: