HRN:_____

NEW PATIENT CHECKLIST

Please bring the following Original documents with your completed application.

- ☐ Birth Certificate
- ☐ Social Security Card
- ☐ Certificate of Indian Blood/Tribal ID
- ☐ Proof of residency (Utility bill, rental agreement)
  - Non-Isleta Tribal members residing on Isleta Pueblo submit Permission to Reside on Pueblo Letter
  - Letter stating Community Ties
- ☐ Valid Identification card or Driver's license

(updated 04/25/2019 JAU)

HRN:_____

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 DATE OF BIRTH

CITY OF BIRTH SEX SOCIAL SECURITY # CURRENT COMMUNITY

MAILING ADDRESS MAILING CITY STATE ZIP CODE

PHYSICAL ADDRESS PHYSICAL CITY STATE ZIP CODE

HOME PHONE OFFICE PHONE CELL/MESSAGE PHONE

TRIBE OF MEMBERSHIP CIB/TRIBAL ENROLLMENT NO. OTHER TRIBE

RELIGIOUS PREFERENCE ARE YOU A VETERAN? YES NO

FATHER'S NAME CITY, STATE OF BIRTH MOTHER'S MAIDEN NAME CITY, STATE OF BIRTH

EMPLOYER'S NAME
SPOUSE EMPLOYER NAME
FATHER'S EMPLOYER NAME
MOTHER'S EMPLOYER NAME

EMERGENCY CONTACT NAME PHONE # RELATIONSHIP

STREET ADDRESS CITY STATE ZIP CODE

NEXT OF KIN NAME PHONE # RELATIONSHIP

STREET ADDRESS CITY STATE ZIP CODE

PRIMARY INSURANCE INFORMATION

INSURANCE NAME

POLICYHOLDER NAME

ID # GROUP #

SECONDARY INSURANCE INFORMATION

INSURANCE NAME

POLICYHOLDER NAME

ID# GROUP #

DENTAL INSURANCE NAME & ID NUMBER
Vision Insurance Behavioral Health

ASSIGNMENT OF BENEFITS: I, THE UNDERSIGNED, HEREBY AUTHORIZE PAYMENT UNDER MY MEDICAL/DENTAL COVERAGE FOR ANY MEDICAL/DENTAL SERVICES AND SUPPLIES RENDERED TO ME TO BE PAID DIRECTLY TO THE *PUEBLO OF ISLETA, HEALTH CENTER.*

SIGNATURE _____ **DATE**_____

CONSENT FOR TREATMENT: I, THE UNDERSIGNED, HERBY GIVE CONSENT TO THE *PUEBLO OF ISLETA, HEALTH CENTER* TO PROVIDE SERVICES AND ADMINISTER PHYSICIAN/DENTIST ORDERS. I UNDERSTAND THAT THE PHYSICIAN/DENTIST IS RESPONSIBLE FOR EXPLAINING MEDICAL/DENTAL DIAGNOSIS AND TREATMENT TO ME AND THAT CERTAIN PROCEDURES REQUIRE A SEPARATE CONSENT.

SIGNATURE _____ **DATE**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: I, THE UNDERSIGNED, HEREBY ACKNOWLEDGE RECEIPT OF THE *PUEBLO OF ISLETA, HEALTH CENTER* NOTICE OF PRIVACY PRACTICES.

SIGNATURE _____ **DATE**_____

HRN:_____

ACKNOWLEDGEMENT OF ELIGIBILITY REQUIREMENTS: I, THE UNDERSIGNED, HEREBY ACKNOWLEDGE RESPONSBILITY TO PROVIDE THE *PUEBLO OF ISLETA, HEALTH CENTER* A COPY OF THE FOLLOWING DOCUMENT(S) AS EVIDENCE OF MY INDIAN BLOOD/DESCENT

_____ Initial CERTIFICATE OF INDIAN BLOOD OR OTHER TRIBAL ENROLLMENT IDENTIFCATION,

_____ Initial BIRTH CERTIFICATE (FOR CHILDREN NOT RECOGNIZED ON A TRIBAL REGISTRY)

I UNDERSTAND THAT FAILURE TO PROVIDE PROOF OF ELIGIBILITY WITHIN 60-DAYS MAY RESULT IN IMMEDIATE DISCONTINUANCE OF NON-EMERGENCY SERVICES AND THAT I MAY BE BILLED FOR ANY SERVICES PREVIOULSY RENDERED.

SIGNATURE _____ **DATE**_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

___Individual refused to sign

___Communication barriers prohibited obtaining the acknowledgement

___An Emergency situation prevented us from obtaining acknowledgement

___Other (Please Specify)_____

_____

_____

IHC EMPLOYEE SIGNATURE _____ **DATE**_____