Pit River Health Service Inc
Medical/Dental/Behavioral Health Clinics
Form: HIM101
MRN:_____
Office Use Only

New Patient Registration Form

Please complete all the information and bring it with you to your office visit.

Personal Information

Last Name:	First Name:	Middle:	Suffix:
Date of Birth:	SSN:	Preferred Language:	
Sex: Female( ) Male( )Marital Status: Divorced( )Married ( )Separated( )Single( )Widow/Widower			
Ethnicity: American Indian/Native American ( ) White ( ) Black/African American ( ) Asian ( ) Pacific Islander ( ) Hispanic or Latino ( ) Don't know or Declined to answer ( )			
Email:		Place of Birth:	
Do you have an Advanced Directive? Yes ( ) No ( )		Do you have a Power of Attorney? Yes ( ) No ( )	
Internet Access? Yes ( ) No ( ) If yes, where at? Home( ) Work( ) School( ) Other ( )			

Advanced Directive (living will) If you have any question or are interested in this form please ask!

Demographics

Physical Address:	City:	State:	Zip:
Mailing Address (If different):	City:	State:	Zip:
Present Community:	Date moved to community:	Place of Birth:	
Home Phone:	Cell Phone:	Message Phone:	

Employment History

Employer Name:		Work Phone:	
Address:	City:	State:	Zip:
Status: Full-time ( ) Part-time ( ) Estimated Monthly Family Income: $		#In Household:	
Religious Preference:			

Parent/Legal Guardian:

Parent/Legal Guardian #1:	Birthdate:	Birthplace:
Type of Guardian: Biological ( ) Adoptive ( ) Foster ( ) Other:		
Parent/Legal Guardian #2:	Birthdate:	Birthplace:
Type of Guardian: Biological ( ) Adoptive ( )Foster ( ) Other:		

Veteran Status:

Are you a Veteran? Yes ( ) No ( )	If yes, which branch?
Valid VA Card? Yes ( ) No ( )	Please give card to registration clerk.

Migrant/Homeless:

Migrant worker? Yes( ) No( ) Migrant Worker Type: Migrant Ag Worker( ) Seasonal Migrant Worker ( )
Are you Homeless? Yes( )No( )Homeless Type: Homeless Shelter( )Street( )Transitional( )Other( )

Insurance/Guarantor:

Company Name:			Phone:
Address:	City:	State:	Zip:
Policy Holder Name:	Relationship:		
Policy Number:	Coverage Type:		
Eligibility Start Date:	Member Number:		
Company Name:			Phone:
Address:	City:	State:	Zip:
Policy Holder Name:	Relationship:		
Policy Number:	Coverage Type:		
Eligibility Start Date:	Member Number:		

****** BRING ALL INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT – WE WILL NEED TO SCAN THEM INTO OUR RECORD ******

Next of Kin:

Name:	Relationship:		
Address:	City:	State:	Zip:
Phone:	Work Phone:		

Emergency Contact:

Name:	Relationship:		
Address:	City:	State:	Zip:
Phone:	Work Phone:		

Native American Descendancy

Are you of Native American descendancy? Yes ( ) No ( )	Indian Blood Quantum:	
Tribal Membership:	Tribe Quantum:	Tribal Enrollment Number:

Tribal Documentation: Grandparents Indian Verification/Parents County Birth Certificates/Patient Birth Certificate
To Prove Descendancy: Parents Indian Verification/Patient Birth Certificate

*******BRING ALL TRIBAL IDENTIFICATION WITH YOU TO YOUR APPOINTMENT – WE WILL NEED TO SCAN THEM INTO OUR RECORD*******

Print Name:
Signature: Date:
Relationship to Patient:

By signing here you are agreeing that the details given on this form are true and correct.

Office use Only:
Received by:_____ Date:_____
Scanned by:_____ Date:_____

MRN:_____