Snoqualmie Behavioral Health Services | Purchased/Referred Care Patient Registration Form

Patient Information		
Last Name:	First Name:	Middle Initial:
Street Address:	City/State/Zip Code:	
Date of Birth:	Place of Birth: *city and state*	Social Security Number:
Gender: Male| Female| Transgender| Gender Neutral	Marital Status: Single| Married| Divorced| Widowed | Separated	Primary Language:
Phone Number:	Cell Number:	
Email Address: Do we have permission to send generic health information to this email address? ☐ Yes ☐ No		
Emergency Contact Name, Phone #, and Relation:	Pharmacy Name/Phone:	
Other Members in the Household/Relationship:		

Race/Ethnicity-Must Provide Proof of Tribal Membership at Initial Appointment

Please check all that apply

RACE:

☐ American Indian or Alaska Native- proof of Tribal affiliation must be provided ☐ Asian ☐ White or Caucasian
☐ Non-Native Clinical Family Member of Native American ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ Decline to Answer

ETHNICITY:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

If identifying as American Indian or Alaska Native, please complete the following		
Father's Name:	City/State of Birth:	Tribe:
Mother's Maiden Name:	City/State of Birth:	Tribe:
Tribal Affiliation:	Blood Quantum:	Enrollment Number:

Employer Information		
Name:	Work Phone:	Occupation:
Address:	City/State/Zip Code:	

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Insurance Information *Copy of Insurance, Medicaid, or Medicare card must be presented at each visit*		
Primary Insurance Company:		
Insurance ID Number:	Group Number:	
Subscriber's Name:	Social Security #:	Date of Birth:
Secondary Insurance Company:		
Insurance ID Number:	Group Number:	
Subscriber's Name:	Social Security #:	Date of Birth:

Guarantor Information *Person responsible for the bill or parent of minor child*		
Name:	Social Security #:	Date of Birth:
Relationship to the patient: *please check* ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____		
Address:	Phone Number:	
Employer Name:	Employer Phone Number:	
Employer Address:	City/State/Zip Code:	

Minor Tribal Child 1.		
Last Name:	First Name:	Middle Initial:
Address: *if different than above*		Date of Birth:
Place of Birth: *city and state*	Social Security Number:	Gender: Male| Female| Transgender| Gender Neutral
Tribal Affiliation:	Blood Quantum:	Enrollment Number:

Insurance Information:
Does the child have the same insurance as above? ☐ Yes ☐ No
If yes, what is the Guarantor's relationship with the child? _____
Does the child have other insurance not listed above? ☐ Yes ☐ No
If you answered yes, please complete the information below

Other Insurance Company: *please include the insurance Name, ID and Group number*		
Guarantor Name:	Social Security #:	Date of Birth:
Guarantor's Employer Information: *name, phone number*	Guarantor's relationship with the child	

Minor Tribal Child 2.		
Last Name:	First Name:	Middle Initial:
Address: *if different than above*		Date of Birth:
Place of Birth: *city and state*	Social Security Number:	Gender: Male| Female| Transgender| Gender Neutral
Tribal Affiliation:	Blood Quantum:	Enrollment Number:
Insurance Information: Does the child have the same insurance as above? ☐ Yes ☐ No If yes, what is the Guarantor's relationship with the child? _____ Does the child have other insurance not listed above? ☐ Yes ☐ No *If you answered yes, please complete the information below*		
Other Insurance Company: *please include the insurance Name, ID and Group number*		
Guarantor Name:	Social Security #:	Date of Birth:
Guarantor's Employer Information: *name, phone number*	Guarantor's relationship with the child	
Minor Tribal Child 3.		
Last Name:	First Name:	Middle Initial:
Address: *if different than above*		Date of Birth:
Place of Birth: *city and state*	Social Security Number:	Gender: Male| Female| Transgender| Gender Neutral
Tribal Affiliation:	Blood Quantum:	Enrollment Number:
Insurance Information: Does the child have the same insurance as above? ☐ Yes ☐ No If yes, what is the Guarantor's relationship with the child? _____ Does the child have other insurance not listed above? ☐ Yes ☐ No *If you answered yes, please complete the information below*		
Other Insurance Company: *please include the insurance Name, ID and Group number*		
Guarantor Name:	Social Security #:	Date of Birth:
Guarantor's Employer Information: *name, phone number*	Guarantor's relationship with the child	

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Minor Tribal Child 4.		
Last Name:	First Name:	Middle Initial:
Address: *if different than above*		Date of Birth:
Place of Birth: *city and state*	Social Security Number:	Gender: Male| Female| Transgender| Gender Neutral
Tribal Affiliation:	Blood Quantum:	Enrollment Number:

Insurance Information:
Does the child have the same insurance as above? ☐ Yes ☐ No
If yes, what is the Guarantor's relationship with the child? _____
Does the child have other insurance not listed above? ☐ Yes ☐ No
If you answered yes, please complete the information below

Other Insurance Company: *please include the insurance Name, ID and Group number*

Guarantor's Employer Information: *name, phone number*	Social Security #:	Date of Birth:
Guarantor's Employer Information: *name, phone number*	Guarantor's relationship with the child	

Other Information

Are you a Veteran? ☐ Yes ☐ No	Branch:	Enter Date:	Discharge Date:
Are you Homeless? ☐ Yes ☐ No	Type: ☐ Homeless Shelter ☐ Transitional ☐ Other:		
Internet access? ☐ Yes ☐ No	Type: ☐ Health Care Facility ☐ Home ☐ Library ☐ Mobile Device ☐ School ☐ Work ☐ Tribe/Community Center		
Preferred method of communication? ☐ Email ☐Letter ☐ Phone ☐ Do not notify		Are you a migrant worker? ☐ Yes ☐ No	

I certify that the above information is true and accurate to the best of my knowledge. I authorize the Snoqualmie Indian Tribe Health Services to verify the accuracy of this application.
Please note: this form must be updated every three (3) years with patient/guardian date and signature.
Furthermore, I certify that I received the Notice of Privacy Practices with the application.

Patient/Legal Guardian Signature: _____ Date: _____

Patient Name: _____