Purchased/Referred Care Patient Registration Form
For Pregnant Non-Native Mother Expecting a Snoqualmie Child

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

Proof of Native Lineage-complete the following section with the Snoqualmie Tribal Father's information		
Father's 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*		
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:	

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: An application must be filled out for each pregnancy and will only cover the period from the approved application through six weeks postpartum. PRC will only cover pregnancy related medically necessary care and services. If unmarried, the enrolled tribal father must state in writing that he is the father of the unborn child to qualify for PRC
Furthermore, I certify that I received the Notice of Privacy Practices with the application.

Patient/Legal Guardian Signature: _____ Date: _____

Patient Name: _____