YSLETA DEL SUR PUEBLO HEALTH AND HUMAN SERVICES
PATIENT REGISTRATION/HEALTH CARE APPLICATION

If patient is under 18, form must be completed and signed by the parent or legal guardian. **CHART #_____**

NAME: _____OTHER NAMES: _____
LAST FIRST MIDDLE

SEX: _____SOCIAL SECURITY NUMBER: _____RELIGION:_____

DATE OF BIRTH: _____CITY OF BIRTH: _____STATE:_____

TRIBE: _____INDIAN BLOOD QUANTUM: _____ENROLLMENT NUMBER: _____RACE:_____

PRESENT COMMUNITY: _____/_____
CITY OR PUEBLO DATE MOVED TO PRESENT COMMUNITY

HOME ADDRESS: _____/_____/_____/_____
STREET ADDRESS CITY STATE ZIP CODE

TELEPHONE: _____/_____/_____/_____
HOME WORK CELLULAR/ALTERNATE# E-MAIL ADDRESS

_____/_____
EMPLOYER NAME PHONE#

_____/_____
EMPLOYER ADDRESS FULL TIME/PART TIME

_____/_____/_____/_____/_____/_____
PRIMARY CARE PROVIDER ADDRESS CITY STATE ZIP CODE PHONE #

MARITAL STATUS: MARRIED DIVORCED NEVER MARRIED SEPARATED SINGLE WIDOW/WIDOWER

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_____/_____
SPOUSE'S NAME EMPLOYER

_____/_____/ FULL TIME_____ PART TIME_____
EMPLOYER ADDRESS PHONE#

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ETHNICITY: ____HISPANIC/LATINO ____NOT HISPANIC/LATINO ____DECLINED TO ANSWER ____UNKNOWN

PRIMARY LANGUAGE SPOKEN IN THE HOME: _____OTHER LANGUAGE SPOKEN:_____

PREFERRED LANGUAGE: _____ MIGRANT WORKER: ___YES ___NO/HOMELESS: ___YES ___ NO

DO YOU HAVE INTERNET ACCESS: _____ YES _____NO WHERE IS THIS ACCESSIBLE: _____

****

ARE YOU A VETERAN: _____YES _____NO /SERVICE BRANCH (LAST):_____

ARE YOU CURRENTLY RECEIVING SERVICES FROM A VA FACILITY: ___ IF YES WHERE: _____

_____/_____/_____/_____/_____
ADDRESS CITY STATE ZIP CODE PHONE #

CONNECTED TO SERVICE MEMBER: ___YES ___NO / NAME:_____BRANCH:_____

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FATHERS NAME_____CITY OF BIRTH_____STATE_____

MOTHERS NAME (MAIDEN)_____ CITY OF BIRTH_____STATE_____

_____/_____/_____
EMERGENCY CONTACT RELATIONSHIP PHONE
ADDRESS: _____CITY:_____STATE:_____ZIP CODE: _____

PREFERRED METHOD OF CONTACT: MAIL___ HOME#___ CELL#___ WORK#___ E-MAIL___ EMERGENCY#___

AUTHORIZATION FOR HHS TO LEAVE VOICEMAIL MESSAGES ON NUMBERS PROVIDED: YES_____ NO _____

RESPONSIBLE PARTY

MOTHER FATHER LEGAL GUARDIAN FOSTER PARENT GRANDPARENT OTHER:_____

_____/_____/_____
NAME DATE OF BIRTH SOCIAL SECURITY #

_____/_____/_____/_____
ADDRESS CITY STATE ZIP CODE

_____/_____/_____
HOME PHONE# CELL# EMAIL ADDRESS

_____/_____
EMPLOYER NAME PHONE#

_____/_____
EMPLOYER ADDRESS FULL TIME/PART TIME

PRC IS NOT AN INSURANCE

_____ **Medical/Dental/Vision/RX**
PRIMARY INSURANCE:
_____/_____
INSURANCE ADDRESS PHONE#
_____/_____
GROUP# ID#
_____/_____
POLICY HOLDER SOCIAL SECURITY #
_____/_____
RELATIONSHIP TO INSURED DATE OF BIRTH
_____/_____
EMPLOYER NAME PHONE#
_____/_____
EMPLOYER ADDRESS FULL TIME/PART TIME

MEDICARE NUMBER: _____MEDICARE PLAN:_____

MEDICAID NUMBER: _____ MEDICAID PLAN:_____

DENTAL INSURANCE:_____VISION INSURANCE: _____

COMPANY NAME/ADDRESS: _____

PLEASE READ BEFORE SIGNING:
PRIVACY ACT OF 1974, PUBLIC LAW 93-579: I UNDERSTAND THAT THE INFORMATION GIVEN BY ME AND/OR COLLECTED IS NECESSARY FOR THE INDIAN HEALTH SERVICES STAFF OR I.H.S. CONTRACTORS TO PROVIDE SERVICES FOR MY HEALTH AND WELL BEING. FURTHERMORE, I HAVE BEEN INFORMED THAT MY MEDICAL RECORD OR ANY PORTION OF THE RECORD SHALL NOT BE DISCLOSED TO ANOTHER AGENCY OR PERSON WITHOUT MY WRITTEN CONSENT, UNLESS SPECIFIED ON THE "WHY WE ASK QUESTIONS" NOTICE. I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND CORRECT AND I HAVE BEEN PROVIDED A COPY OF THE "PATIENT'S BILL OF RIGHTS."
I UNDERSTAND THAT THIS FORM MUST BE UPDATED ANNUALLY.

SIGNATURE: _____DATE:_____

INTERVIEWED BY: _____DATE:_____