Indian Health Council
50100 Golsh Rd
Valley Center CA 92082
760-749-1410

Empowering Native Wellness

NEW PATIENT WELCOME LETTER

We at Indian Health Council, Inc. wish to take a moment to welcome you to our practice!

We want you to know that we appreciate the opportunity to take care of you and your family. Thank you for selecting us as your patient centered home and we look forward to serving you. Our goal is to provide you with the best coordinated, highest quality care. To reach this goal our skilled professionals take a personalized approach to care by sitting down with you and discussing your healthcare needs and treatment.

Your health is our primary concern. Our philosophy is to provide comprehensive care while treating every patient with dignity and respect. We treat a full spectrum of both acute illnesses and chronic conditions and offer a wide variety of services and preventive programs to address your physical, mental, and spiritual well being. ***"We Empower Native Wellness."*** In order to expedite the new patient registration process, we ask that you ***complete*** the following forms:

PATIENT REGISTRATION/INTAKE FORM

CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

FINANCIAL SCREENING FORM

MEDICAL HEALTH HISTORY (Child or Adult)

OFFICE POLICY NOTICE TO PATIENTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF ADVANCE DIRECTIVE INFORMATION (18 OR OLDER)

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

In addition, to completing these forms, we ask that you ***read*** the documents containing information on IHC's **PRIVACY PRACTICES**, **ADVANCE DIRECTIVE INFORMATION** and our **DENTAL MATERIALS FACT SHEET**. Other information that is needed to determine your eligibility for services includes the following documentation to be ***brought into*** IHC to Central Registration:

- ☐ **PROOF OF INDIAN (*BIA Letter, Tribal ID Card or Tribal Letter)***
- ☐ **PROOF OF RESIDENCY (*Current Utility Bill, DMV Registration, Rental/Lease Agreement)***
- ☐ **INSURANCE CARD**
- ☐ **COPY OF SOCIAL SECURITY CARD**
- ☐ **MARRIAGE CERTIFICATE *(If Non-Indian Spouse)***
- ☐ **BIRTH CERTIFICATE *(If Child/Minor)***
- ☐ **PROOF OF INCOME *(If uninsured)***

Again, thank you for choosing us. We look forward to seeing you at the clinic and will do our best to make your visit as pleasant, efficient and complete as possible.

Sincerely,

Indian Health Council, Inc.

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Chart # _____

PATIENT REGISTRATION/INTAKE FORM

Patient's Legal Name: _____
Last First M.I. (Maiden)

Other Names Known by: _____Soc.Sec.# _____- _____ -_____

Home Address: _____
Street City State Zip

Mailing Address: _____
Street/PO Box City State Zip

Home Ph#: ( ) _____Work Ph#: ( ) _____Cell Ph#( ) _____

Date of Birth: _____ Birthplace: _____ Sex: F M Email:_____

Marital Status: Single Married Child/Infant Spouse's Name: _____

Race: American Indian African American Asian Hispanic Pacific Islander White Decline to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to Report

Tribe: _____ Tribal Roll #: _____

Occupation: _____ Name of Employer: _____

U.S. Veteran: Yes No Service Branch: _____

Vietnam Vet: Yes No Separation Date: _____

Father's Name: _____ _____ _____
Father's Birthplace Father's Tribe

Mother's Maiden Name: _____ _____ _____
Mother's Birthplace Mother's Tribe

Person to Contact In Case of Emergency: _____
Name Relationship

_____
Street City State Zip

_____
Phone #

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	Primary Medical Insurance	Secondary
Medical Insurance		
Insurance Carrier:	_____	_____
Carrier's Phone # :	_____	_____
Employer:	_____	_____
Policy # :	_____	_____
Group # :	_____	_____
Subscriber:	_____	_____
Relationship to Patient:	_____	_____

	Primary Dental Insurance	Secondary Dental Insurance
Insurance Carrier:	_____	_____
Carrier's Phone # :	_____	_____
Employer:	_____	_____
Policy # :	_____	_____
Group # :	_____	_____
Subscriber:	_____	_____
Relationship to Patient:	_____	_____

If you are currently uninsured please complete the following:

Income Information: # of Persons in the Household 1 2 Adults
1 2 3 4 5 6 7 Children

Please check approximate Yearly Income:

0 - $10,000 $10,001- $25,000 $25,001- $40,000 $40,001- $55,000

$55,001-$65,000 over $65,000

Person responsible for payment: _____
Name Relationship

_____
Street City State Zip

Certification Statement: I certify that the information above is true and accurate to the best of my knowledge.

_____
Name of Patient (Print)

_____
Name of Responsible Party (Print)

_____
Date

_____
Signature of Responsible Party

_____
Drivers License #