Chart Number_____

FILL OUT THIS FORM COMPLETELY

PATIENT REGISTRATION *Confidential*

Las Vegas Paiute Tribe Health & Human Services, 1257 Paiute Circle, Las Vegas, NV 89106 702.382-0784

When did you move to Clark County?_____ Social Security #_____/_____/_____

LEGAL NAME OF PATIENT: _____ ( ) Male ( ) Female
(Last) (First) (Middle)

Other Names Used: _____ Religion: _____

Birth Date: _____ **Place of Birth**: City: _____**State**: _____ **Marital Status**: ( )Single ( )Married ( )Divorced ( )Widowed

Mailing Address: _____
(Street or Box Number) (City/State) (Zip)

Home Phone: _____ Cell Phone: _____Message Phone: _____

EMPLOYER (Parent/Guardian if applicable):_____ Employer Phone #:_____

Employer Full Address:_____

Internet Access? ( )YES ( )NO If YES, Where? ( )Home ( )Work ( )Mobile ( )School ( )Other _____

E-Mail Address: _____

Total in Household: _____ Total Household Income: _____ / ( )Bi-Weekly ( )Monthly ( )Weekly ( )Yearly

Primary Language: _____ Secondary Language: _____Interpreter required? ( )YES ( )NO

Are you a Veteran? ( )YES ( )NO Branch: _____ Entry Date:_____ Discharge Date:_____

ARE YOU AN ENROLLED MEMBER OR A DESCENDANT OF A FEDERALLY RECOGNIZED TRIBE IN THE UNITED STATES? ( ) YES ( ) NO

Tribe of Membership: _____ Tribe Quantum: _____ Total Blood Quantum: _____ Enrollment #: _____

FATHER'S Full Name: _____ Birthplace: _____ Tribe (Federally Recognized) _____

MOTHER'S Full Name: _____ Birthplace: _____ Tribe (Federally Recognized) _____
(**Maiden** Name)

EMERGENCY CONTACT: _____ ADDRESS: _____ _____

RELATIONSHIP: _____ PHONE: _____

NEXT OF KIN: _____ ADDRESS: _____

RELATIONSHIP: _____ PHONE: _____

Important **HEALTH INSURANCE INFORMATION - BRING YOUR CARD TO EVERY VISIT**

DO YOU HAVE MEDICAL INSURANCE? ( ) YES ( ) NO PHARMACY INSURANCE? ( ) YES ( ) NO

TYPE OF COVERAGE: Policy # of Insurance DATE Eligibility Began

( ) Medicaid/NV Check-up _____ _____

( ) Medicare A or B (please circle) _____ _____

( ) **Private Insurance** **(Continue Below)** _____ _____

NAME OF HEALTH INSURANCE: _____ HEALTH INSURANCE PHONE #: _____

POLICY HOLDER NAME: _____ PATIENT RELATIONSHIP TO HOLDER: ( )SELF ( )SPOUSE ( )CHILD

HOLDER'S DOB: _____/_____/_____ HOLDER'S SOCIAL SECURITY #: _____-_____-_____ HOLDER'S EMPLOYER _____

EMPLOYER'S ADDRESS: _____ PHONE #: _____

I CERTIFY THE ABOVE INFORMATION TO BE ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE THE LAS VEGAS PAIUTE TRIBE HEALTH & HUMAN SERVICES TO VERIFY THE ACCURACY OF THIS APPLICATION.

_____ _____
PATIENT SIGNATURE (Parent or Guardian if under 18) DATE

OFFICE USE ONLY ****DOCUMENTS MUST BE PROVIDED at the next office visit or within 30 DAYS OF REGISTERING****

RECV'D	NEED	
_____	_____	TRIBAL ENROLLMENT/DESCENDANT
_____	_____	BIRTH CERTIFICATE
_____	_____	DRIVERS LICENSE or PICTURE ID
_____	_____	PROOF OF RESIDENCY-RENT/UTILITY RECEIPT
_____	_____	PRIVATE INSURANCE INFORMATION
_____	_____	MEDICARE AND/OR MEDICAID INFORMATION
_____	_____	SOCIAL SECURITY CARD~~~~~~~~~~~~~~VISUALLY VERIFIED/STAFF INITIAL_____