FourPoints HEALTH

FourPointsHealth.org

PATIENT REGISTRATION AND INFORMATION

PATIENT INFORMATION

Patient Last Name:	First Name:	Preferred Name:	Middle Name

Suffix (Jr, Sr., II, etc.)	Sex (Circle One) Male Female	Date of Birth:	Social Security Number:

Address	City	State	Zip Code:

Home Phone	Work Phone	Patient Email:

Cell Phone	Consent to text (Circle One) Yes No	Patient Portal Access Circle One Yes No	Contact Preference (Circle One) Phone Mail Portal

Preferred Language (Circle One): English Spanish Other:_____ Decline	Race (Circle One): American Indian African American Islander White Other_____ Decline
Marital Status (Circle One): Single Married Divorced Widowed Separated Partner Decline	Indian Blood Quantum (IF APPLICABLE): / Tribe of Membership
Ethnicity (Circle One) : Not Hispanic/Latino Hispanic/Latino Other_____ Decline	Live on Reservation Yes No Tribal Enrollment Number:
Family Size: _____ Estimated Income_____ (Circle One): Annual Monthly Bi-weekly, Weekly	Sexual Orientation (Select One) Lesbian/Gay/Homosexual Straight/Heterosexual Bisexual Choose not to Disclose
Agriculture Worker: Yes No Decline	
Homeless: Yes No Decline	
School Based Health Center Patient Yes No Decline	Gender Identity (Select One) Male Female Transgender Gender Queer Choose not to Disclose
Veteran Status Yes No Decline	
Public Housing Patient Yes No Decline	

Employer Name	Employer City	Employer State	Employer Zip Code:

Occupation:	Employment Status (Circle One): Full-Time Part-Time Act Military Retired Self Unemployed

GUARDIAN & EMERGENCY CONTACT INFORMATION

Legal Guardian Last Name (if applicable):	Guardian First Name	Guardian Middle Name

Emergency Contact Name:	Next of Kin Name:
Relationship	Next of Kin Relationship (Circle One):
Phone:	Spouse Parent Child Sibling Fiend Cousin Guardian Other

INSURANCE INFORMATION - PLEASE PROVIDE COPY OF CURRENT INSURANCE CARD

TYPE OF PRIMARY COVERAGE MEDICAID MEDICARE PRIVATE INSURANCE NONE OTHER

Primary Insurance Company	Effective Date	Expiration Date

Primary Policy Holder Name	Member ID	Group Number:

Patient's relationship to policyholder (Circle One) Husband Wife Self Parent Grandparent Guardian

TYPE OF SECONDARY COVERAGE (IF APPLICABLE) MEDICAID MEDICARE PRIVATE INSURANCE NONE OTHER

Secondary Insurance Company (If Applicable)	Effective Date	Expiration Date

Policy Holder Name	Member ID	Group Number:

Patient's relationship to policyholder (Circle One) Husband Wife Self Parent Grandparent Guardian

AUTOMATIC NOTIFICATION PREFERENCE

I would like to be contacted through automatic messages for the following (Circle all that apply):

Health Notifications:	Email	Phone	Text Message
Appointments:	Email	Phone	Text Message
Announcements:	Email	Phone	Text Message
Billing:	Email	Phone	Text Message

I don't want to be contacted for automatic messaging _____ (Please Initial)

I, the undersigned, certify that the information contained on this form is correct to the best of my knowledge. Furthermore, I authorize the release of any medical information necessary to process the claim for treatment, payment, or operations. I authorize payment of medical benefits to Paiute Indian Tribe of Utah, provider or suppliers for services. I assign my insurance benefits be paid directly to the Paiute Indian Tribe of Utah. I herby authorize the provider and whomever else he/she may designate as his/her assistant(s), to administer those treatments and procedures which in his/her opinion are deemed necessary. I herby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is expected at the time of service. We will bill your insurance as a courtesy.

_____ _____

PATIENTS OR LEGAL GUARDIAN SIGNATURE Date

If patient is a minor, must be signed by guardian listed on application

PATIENT REGISTRATION FORM MUST BE COMPLETED IN FULL TO BE SEEN BY A PROVIDER, NO EXCEPTIONS