FALLON PAIUTE-SHOSHONE TRIBE
FALLON TRIBAL HEALTH CENTER
1001 Rio Vista Drive • Fallon, Nevada 89406-5463
Tel 775-423-3634 • Fax 775-423-2287 • www.fthcnv.com

PATIENT/CLIENT REGISTRATION FORM

Patient Registration Form 300-1 (Rev. Apr 2023)

PERSONAL INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

PREVIOUS NAMES USED _____ ☐ Maiden Name ☐ Former Married Name

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHYSICAL ADDRESS (if different from above) _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # _____ CELL PHONE # _____ EMAIL ADDRESS _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

PARENTS OF MINORS OR ADULT GUARDIANSHIP INFORMATION

(only for individuals under 18 years of age or adults under legal guardianship or power of attorney)

Minor's Parents:

MOTHER'S MAIDEN NAME _____ PLACE OF BIRTH (CITY, STATE) _____

FATHER'S NAME _____ PLACE OF BIRTH (CITY, STATE) _____

Guardianships:

NAME OF ADULT LEGAL GUARDIAN _____ ☐ Court Order ☐ Power of Attorney

EMERGENCY CONTACT AND NEXT OF KIN

Name (primary) _____ ☐ Emergency Contact ☐ Next of Kin

Relationship _____ Telephone: _____

Address: _____

Name (secondary) _____ ☐ Emergency Contact ☐ Next of Kin

Relationship _____ Telephone: _____

Address: _____

ELIGIBILITY FOR DIRECT HEALTHCARE SERVICES

To be eligible for direct healthcare services through the Fallon Tribal Health Center, an individual has to be an American Indian, Alaska Native (AI/AN) or an Eligible Non-Indian based on applicable Tribal and/or IHS policies. Please check the box that matches evidence of service eligibility.

American Indian and/or Alaska Native categories

- ☐ Enrolled with Federally-Recognized Tribe
- ☐ Descendent of a Federal Recognized Tribal Member (attach a CIB or descendant's enrollment information)

Eligible Non-Indian categories

- ☐ Child of Eligible AI/AN (natural/adopted, stepchild, foster child, legal ward, orphan of an eligible AN/AI)
- ☐ Non-Indian Woman pregnant with eligible AI/AN's child (during the duration of pregnancy and post-partum)
  - Paternity established by: ☐ Eligible AI/AN in writing ☐ Court Order
- ☐ Non-Indian Member of eligible AI/AN's household (only for public health hazards or acute infectious diseases)

AI/AN verification by: ☐ Membership Card ☐ BIA Certificate of Indian Blood (CIB) ☐ Official Tribal Letter

Name of Federally Recognized Tribe enrolled with or that descendancy is claimed from _____

Membership/Enrollment Number _____

ELIGIBILITY FOR PURCHASED/REFERRED CARE SERVICES

To be eligible for Purchased/Referred Care ("PRC") services through the Fallon Tribal Health Center a person has to be eligible for Direct Healthcare Services and meets our PRC Eligibility Requirements. To determine your eligibility for PRC services, you may need to complete a PRC application form (contact our PRC Office for more information), as well as complete the requirement to apply for all alternate resources. A final determination of PRC Eligibility will be made by the FTHC based on applicable Tribal and/or IHS policies.

DEMOGRAPHIC INFORMATION

Race
☐ American Indian/Alaska Native ☐ White/Caucasian ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ Decline to Answer

Ethnicity
☐ Non-Hispanic/Latin ☐ Hispanic ☐ Decline to Answer

Marital Status
☐ Decline to Answer ☐ Single ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Employment
☐ Working Full-Time ☐ Working Part-Time ☐ Retired
☐ Unemployed/Laid-Off ☐ Student ☐ Other

Employer/School Name _____

Address _____ Phone # _____

U.S. Veteran? ☐ Yes ☐ No Branch: _____ Service Dates: _____

SEXUAL ORIENTATION AND GENDER IDENTITY

Preferred Pronoun ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs
☐ Decline to Answer ☐ Other: _____

Legal Sex (assigned at birth) ☐ Male ☐ Female ☐ Not Listed

Gender Identity (OPTIONAL) ☐ Male ☐ Female ☐ Non-Binary
☐ Transgender Female (Male to Female) ☐ Decline to Answer
☐ Transgender Male (Female to Male)

Sexual Orientation (OPTIONAL) ☐ Straight/Heterosexual ☐ Lesbian, Gay, or Homosexual
☐ Bisexual ☐ Something Else ☐ Decline to Answer

HEALTHCARE INSURANCE INFORMATION

NAME OF INSURANCE COMPANY _____ MEMBER ID / GROUP # _____

NAME OF POLICY HOLDER _____ HOLDER'S SSN _____ HOLDER'S DOB _____

RELATIONSHIP TO PATIENT _____ EMPLOYER THAT POLICY IS UNDER _____

OTHER INSURANCE: Medicare: ☐ No ☐ Yes ID # _____

Nevada Medicaid/Check-Up: ☐ No ☐ Yes ID # _____

ADVANCED DIRECTIVES/LIVING WILL

I have an Advanced Directive/Living Will: ☐ No ☐ Yes (if yes please attach a copy for your file)

I want to complete an Advanced Directives document: ☐ No ☐ Yes ☐ I would like information on this

PATIENT/CLIENT ACKNOWLEDGEMENT

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Patient/Client Registration form. I further certify that I am the patient/client or legally authorized by the patient/client to accept the terms of this form, and I know and understand the contents thereof.

SIGN HERE _____ _____

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN DATE SIGNED