PONCA TRIBE OF NEBRASKA

REGISTRATION FORM

(Please Print)

Tribal Information:	SS#

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid
Current Street address:		Home/Cell phone #:	DOB:
P.O. Box:	City:	State:	ZIP Code:

EMPLOYMENT INFORMATION

Employer Name:	Phone #:	❑ Full Time ❑ Part Time
Address/City/Zip:		
Spouse's Employer Name:	Phone #:	❑ Full Time ❑ Part Time
Address/City/Zip:		
Total # people in household:	Total Household Income:	

EMERGENCY CONTACT/NEXT OF KIN

EC-Name:	Address/City/Zip:	Phone #:
Relationship:		
NOK-Name:	Address/City/Zip:	Phone #:
Relationship:		

INSURANCE INFORMATION

****Please give ALL your insurance card(s) to staff or provide a copy of the front and back of the card(s) if mailing****

Is this patient covered by insurance? ❑ Yes ❑ No

❑ Private Insurance: _____ I.D.: _____
(Please List Name)

❑ Medical (Family/Self) ❑ Dental (Family/Self) ❑ Vision (Family/Self)

❑ Medicare: I.D. # _____

❑ Medicaid I.D. # _____

PATIENT SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize Ponca Tribe of Nebraska/Fred LeRoy Health & Wellness Center/Ponca Hills Health & Wellness Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose health care information about you. As provided in our notice, the terms of our notice may change. If we change our terms you may obtain a revised copy.

I, _____ (please print patient name) have received a copy of the Ponca Tribe of Nebraska's Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

PATIENT SIGNATURE: _____ DATE: _____

AUTHORIZED
REPRESENTATIVE: _____

RELATIONSHIP TO
PATIENT: _____

_____ _____
Witness Location Privacy Notice Written Acknowledgement was obtained

DOCUMENTATION OF GOOD FAITH EFFORT

_____ Attempt to distribute the Notice of Privacy Practices to the Patient/Parent/Legal Guardian but the Patient/Parent/Legal Guardian declined to acknowledge the receipt of the Notice of Privacy Practices

_____ Patient/Parent/Legal Guardian stated that they had already received the Privacy Notice

_____ The Notice of Privacy Practices was mailed to the Patient/Parent/Legal Guardian at the last known address of the patient

_____ Other

_____ _____
Witness Date