Navajo Health Foundation
SAGE MEMORIAL HOSPITAL

** MASS FLU VACCINE EVENT 2021 **

STUDENT DAY (School Name: _____Grade:__ Teacher: _____)
COMMUNITY DAY (Community Name: _____)

Acct#_____
SMH#_____

NEW PATIENT: YES NO

BIOGRAPHICAL DATA BASE

PATIENT NAME: _____
LAST FIRST MIDDLE

OTHER NAME(S) USED: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

LOCATION OF HOME: _____

CELL PH#:_____ HM PH#:_____ MSG PH#:_____

DATE OF BIRTH: _____ BIRTH PLACE: _____

SOCIAL SECURITY #:_____-_____-_____ GENDER: _____ CENSUS #:_____

RACE: _____ TRIBE: _____

MARTIAL STATUS: _____ RELIGION: _____

OCCUPATION: _____ EMPLOYER: _____

INSURANCE CO: _____ POLICY HOLDER :_____ POLICY #: _____

SPOUSE NAME: _____ SPOUSE SSN: _____ D.O.B._____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PH#:_____ HM PH#:_____ WK PH#:_____

FATHER'S NAME: _____ SSN: _____

DATE OF BIRTH: _____ BIRTH PLACE: _____ CENSUS #_____

FATHER'S EMPLOYER: _____ PH#_____

MOTHER'S NAME: _____ SSN: _____

DATE OF BIRTH: _____ BIRTH PLACE: _____ CENSUS #_____

MOTHER'S EMPLOYER: _____ PH#_____

GUARDIAN NAME: _____ RELATIONSHP: _____

CONSENT OF TREATMENT COMPLETED? YES NO ON FILE? YES NO CONFIRMED? YES NO

NAME OF PERSON PROVIDING INFORMAION: _____ DATE: _____

PT REG: BIO ___ CONSENT ___ VACCINE FORM___ REGISTERED? YES NO REG CLERK: _____

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CONDITION OF TREATMENT

1. AUTHORIZATION FOR RURAL HEALTH CLINIC TREATMENT
   The undersigned voluntarily agrees to treatment and services that his/her physician deems necessary. There are certain procedures for which special consent will be obtained.

2. RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW:
   Rural Health Clinic may disclose all or any part of the patient's record to include information pertaining to medical history or mental and physical condition to any person or entity for the purpose of billing all or part of the Rural health Clinic charges insurance companies, pre-admission review, or for the purposes related to these activities.

3. FINANCIAL AGREEMENT:
   I understand that payment for health care may be denied by Indian Health Service for patients out of the service area for service not considered to be Emergency Treatment. I also understand that there may be charges not covered by insurance, AHCCCS, or Medicare. The undersigned agrees that in consideration of services rendered to the patient by Sage Outpatient Clinic, he/she is financially responsible for charges not covered I.H.S., Medicare, AHCCCS, or other insurance.

4. ASSIGNMENT OF BENEFITS:
   I hereby authorize payment directly to Sage Memorial Hospital of the health care payment benefits otherwise payable to me but not to exceed the regular charges for services

5. INFORMATION RELEASE WITHIN CLINICS AND HOSPITAL:
   Authorization is hereby given to release information concerning diagnosis and treatment for use between the Ambulatory Services, Rural Health Clinic, Sage Hospital Emergency Room and In-Patient.

DATE PATIENT WITNESS

DATE RELATIVE/LEGAL GUARDIAN WITNESS

Received Patient's Bill of Rights _____ Inform of Waiting Time _____

Received Notice of Privacy Practices _____ Refused Patient Privacy Notice _____

MEDICAL RECORD NUMBER: _____

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