Navajo Health Foundation
SAGE MEMORIAL HOSPITAL

PATIENT REGISTRATION FORM

2022 Influenza Clinic

STUDENTS: (School Name: _____Grade:__ Teacher: _____) Date: _____
COMMUNITY: (Community Name: _____)

Acct#_____ **SMH#**_____ NEW PATIENT: ◯YES ◯NO

BIOGRAPHICAL DATABASE

PATIENT NAME: _____ OTHER NAMES:_____

D.O.B: _____ SSN #: _____ PHONE # _____

BIRTH PLACE: _____ GENDER: _____ MARITAL STATUS: _____

TRIBAL AFFILATION: _____ CENSUS# _____

LOCATION OF HOME: _____

MAILING ADDRESS: _____

INSURANCE CO: _____ POLICY HOLDER: _____

EMPLOYER NAME: _____

PARENT/GUARDIAN NAME (FOR MINORS, 18 YEARS OLD & YOUNGER) BELOW:
LAST NAME: _____ FIRST NAME: _____

PHONE #: _____ CIRCLE ONE: HOME MOBILE MESSAGE

EMERGENCY CONTACT:

LAST NAME: _____ FIRST NAME: _____

PHONE #: _____ CIRCLE ONE: HOME MOBILE MESSAGE

RELATIONSHIP TO PATIENT: _____

REVERSE SIDE – SIGN THE GENERAL CONSENT FORM

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General Consent Form

AUTHORIZATION FOR COMMUNITY 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.

RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW
Community Health Clinic may disclose all or 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 Community Health Clinic charges insurance companies, pre-admission review, or for the purposes related to these activities.

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 Community Health Clinic, he/she is financially responsible for charges not covered I.H.S, AHCCCS, or other insurance.

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.

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

HEALTH INFORMATION EXCHANGE (HIE):
Electronic Health Information Exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically improving the speed, quality, safety, and cost of patient care. Appropriate, timely sharing of vital patient information can better inform decision making at the point of care.

HIE Benefits - To better track and securely share patients' complete medical histories, SMH health care providers are participating in health information exchange (HIE). HIE helps facilitate coordinated patient care, reduce duplicative treatments, and avoid costly mistakes. As an SMH patient are automatically enrolled if no action is taken.

DATE _____ PATIENT SIGNATURE _____ SMH WITNESS _____

DATE _____ RELATIVE/LEGAL GUARDIAN SIGNATURE _____ SMH WITNESS _____

Received Patient Bill of Rights & Notice of Privacy Practices _____ Refused Patient Privacy Notice _____

MEDICAL RECORD NUMBER _____