Peter Christensen Health Center
129 Old Abe Road
Lac du Flambeau, WI 54538
TEL: (715) 588-3371
FAX: (715) 588-2039

New Patient Registration Form

Chart#_____

CONFIDENTIAL INFORMATION

Welcome to the Peter Christensen Health Center! Please fill out this form completely. If you have any questions or concerns, please do not hesitate to ask for assistance, we will be happy to help!

PATIENT INFORMATION:
Patient Name (Last, First, Middle): _____
Nickname or Preferred Name:_____
Maiden/other names used: _____
Race_____ Date of Birth: ____/____/_____
Social Security Number: _____

Marital Status (circle one): M S W D Spouse Name: _____
Sex: ☐Male ☐Female Preferred Gender:_____ Prefer Not to Say: ☐

Mailing Address: _____ City:_____ State: ____ Zip: _____
Street Address (if different): _____
Date Moved to this address: _____ Phone # :_____ Cell# :_____
Work# : _____ Email Address: _____

Employer Name: _____ Employer Address: _____
Employment Status (circle one): Full-Time Part-Time Unemployed

Tribe of Membership (You must provide proof): _____
Tribal Enrollment Number: _____
If not enrolled, then living descendant of which tribe? (You must provide written proof) _____

Who can we contact in case of emergency?
Name: _____
Relationship: _____ Address: _____
Phone: _____

Parental/Legal Guardian Information (Only if patient is under 18 years old):
Father's Full Name: _____
Mother's Full Name: _____
Other Legal Guardian: _____

Do you have any children under the age of 18? ☐ Yes ☐ No
Are you a Veteran? ☐ Yes ☐ No

PRIMARY PROVIDER NAME: _____
Do you need records transferred from another health care facility? ☐ Yes ☐ No
If yes, please **completely** fill out a Release of Information form, available in the new registration packet at the front desk.

INSURANCE INFORMATION: (PLEASE PROVIDE INSURANCE CARDS TO PATIENT REGISTRATION TO BE COPIED AND FILED)

Primary Insurance Information:
Insurance Company Name: _____
Address: _____
Phone # : _____
Policy Number: _____ Plan Coverage: ☐Family ☐Single
Group # : _____
What does the plan cover? (Circle all that apply): Medical / Dental / Vision / Rx / Mental Health
Effective Date: _____ Policy Holder's Name: _____
Address of Policy Holder: _____ Phone # : _____
Relationship to Patient: _____
Policy Holder's SS# :_____ DOB: _____/_____/_____ Sex: ☐ Male ☐Female
Medicaid # : _____ Effective Date: _____/_____/_____
Medicare # : _____ ☐Part A Only ☐Part B Only ☐A&B Eligible
Medicare Part A Effective Date: ___/____/_____ Medicare Part B Effective Date: ____/____/_____

Secondary Insurance Information:
Insurance Company Name: _____
Address: _____ Phone # : _____
Policy Number: _____ ☐Family ☐Single ☐Group# : _____
What does the plan cover? (circle all that apply) Medical / Dental / Vision / Rx / Mental Health
Effective date: _____ Policy Holder's Name: _____
Address of Policy Holder: _____ Phone # : _____
Relationship to Patient: _____
Policy Holder's SS# : _____ DOB: ___/____/_____ Sex: ☐Male ☐Female

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Authorization to Furnish Information and Assignment of Benefits (Private Insurance, Medicare, and Medicaid)

The Peter Christensen Health Center may disclose all or any part of the patient's health record to any person or corporation which is or may be liable under a contract to a hospital, medical service company, insurance company, workers compensation, public aid funds, patient's employer, Medicare, Medicaid, IHS, etc.

I hereby assign to the Peter Christensen Health Center such benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me or dependents included in my insurance policy. I **AUTHORIZE** payment of such benefits to the Peter Christensen Health Center. I understand this assignment will remain in effect until revoked by me in writing. A scanned copied of this assignment is to be considered as valid as the original.

Patient Signature: _____ Date: _____

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Acknowledgment of Receipt of Patient Rights and Responsibilities

As a patient of this facility, you have rights and responsibilities. You have the right to be treated with respect, considerations, and dignity at all times, to have access to information contained in your medical record at PCHC, to accept or refuse any procedure, medication, or treatment, and be informed of the risks of such refusal, etc. You have the responsibility to be respectful of your provider, PCHC staff, visitors, and PCHC property at all times, to follow clinic rules and regulations including those of public health emergency protocols, not using commercial tobacco products within the tobacco-free campus of PCHC, to know that any use of illegal drugs, weapons, or alcohol are not allowed on the PCHC campus and to know that if you are under the influence of illegal drugs and/or alcohol while seeking care, it may impact your plan of care, etc.

My signature on this form acknowledges that I have received a copy of Peter Christensen Health Center's Notice of Patient Rights and Responsibilities. I understand that this document provides an explanation of rights as a patient of PCHC and also my responsibilities as a patient at PCHC.

Patient Signature: _____ Date: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

My signature on this form acknowledges that I have received a copy of Peter Christensen Health Center's Notice of Privacy Practices. I understand these documents provide an explanation of the ways in which my health information may be used or disclosed by PCHC and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Patient Name (printed): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Signature of Patient Representative or Witness (relationship) Date

(If signature is by thumb print or mark)

_____ _____ _____

Signature of PCHC staff member Title Date

TO BE COMPLETED BY PCHC EMPLOYEE IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of PCHC Notice of Privacy Practices? ☐Yes ☐No
2. Briefly describe efforts made to obtain patient's acknowledgment of receipt of the notice and explain why the patient was not able or willing to sign this form:

_____
_____
_____

_____ _____ _____

Signature of PCHC Staff Member Title Date