Samuel Simmonds Memorial Hospital

PATIENT REGISTRATION FORM

Last Name:	First Name:	**CHART #**
Middle (Spell out)	Maiden Name:	
Do you have other names ? YES NO	If "yes" please print name	
Date of Birth:	Place of Birth:	Sex: M F
Social Security Number	Marital Status	Religious Preference
Current Community	What date did you move to Current Community?	
Mailing Address: P.O. Box Town: State: Zip:	Physical Address: ZIP:	
PHONE NUMBER:	Work Number:	Cell/Message:
Father's Name:	Mother's Name:	
Mother's maiden name:	Guarantor:	

Tribe of Membership: (what Federally recognized Tribe do you belong to?) :		
Blood Quantum:	Tribal Enrollment Number:	
Emergency Contact:	Last Name:	First Name:
Phone Number:	Relationship to patient?	Physical Address:
Next of Kin: (Relative)	Last Name:	First Name:
Phone Number:	Relationship to Patient?	Physical Address:
Are you of Hispanic or Lantino decent? YES NO		
Primary language spoken in home?	How well:	
Other Language spoken?		
Are you a migrant worker:? YES NO	Are you homeless? YES NO	
Do you have internet access? YES NO	At home ? Work?	

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PATIENT REGISTRATION FORM

Patient or Parent's employer?					
Are you :	Full time	Part time	Unemployed	Self employed	Retired
Do you have private insurance?		YES	NO		
Insurance Company Name?					
Policy Holders name:			Policy holders date of birth:		
Policy Number?		Group Number?		Effective Date:	

Spouse or Parent's employer:					
Are you :	Full time	Part time	Unemployed	Self employed	Retired
Do you have private Insurance?		YES	NO		
Insurance Company Name:					
Policy Holder Name			Policy Holder's Date of Birth:		
Policy Number		Group #		Effective Date:	

Do you have Medicaid?	YES	NO	Do you have Denali Kid Care?	YES	NO
Do you have Medicare?	YES	NO	Are you a Veteran?	YES	NO

PLEASE PROVIDE CLERK WITH ALL INSURANCE CARDS AND CIB/BIA CARDS