New Patient Registration Required Documentation

- **FLORIDA I.D. (**BOTH PARENTS FOR CHILDREN**)**
- **TRIBAL I.D.**
- **SOCIAL SECURITY CARD**
- **BIRTH CERTIFICATE**
- **HOSPITAL DOCUMENTS (**FOR NEWBORNS**)**
- **COMPLETED ROI**
- **COMPLETED INTERNAL HIPAA POLICY**

MICCOSUKEE HEALTH DEPARTMENT
Patient Registration Form

Patient's Name (Last, First, MI): ______________________________

Patient's Home Phone Number: ______________ Alternate Phone Number ☐ cell or ☐ work: ______________

E-mail Address: ______________ Address: ______________

Apt. # ____________City: ____________ State: ____________ Zip Code: ______________

Date of Birth: ____________ Age: _______ Sex: ☐ Male ☐ Female - Social Security Number:______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient's Employer: ______________________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student ☐ Other: ______________

Emergency Contact: ______________ Relationship to Patient: ______________

Address: ______________ Phone Number: ______________

<u>We will need to see your Tribal ID Cards with Picture photo, Driver's License and Social Security Card</u>

Are you an enrolled member of a Federally recognized Tribe ☐ Yes ☐ No / Name of Tribe: ______________

Address: ______________ Phone No: ______________ Indian Blood Quantum: ____________

Father's Name: ______________ Place of Birth: City ____________ State: ____________

Mother's Name: ______________ Place of Birth: City ____________ State: ____________

<u>INSURANCE INFORMATION</u>

Primary Care Physician: ______________ Address: ______________ Phone No: ____________

Primary Insurance: ______________ Secondary Insurance: ______________

Patient is Subscriber/Policy Holder: ☐ YES ☐ NO Patient is Subscriber/Policy Holder: ☐ YES ☐ NO

<u>INSURED INFORMATION (IF OTHER THAN PATIENT) – We will request to scan your ID and Insurance Card.</u>

Subscriber / Policy Holder: ______________ Relationship to Patient: ______________

Address: ______________________________

Date of Birth: ______________ Social Security Number______________

His or Her Employer Name: ______________ Work Phone Number:______________

<u>RELEASE OF INFORMATION</u>

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name (s): ______________ Relationship to Patient: ______________

Please call the Clinic to cancel with 24 hour notice at 305-894-2387.

Patient / Parent or Guardian Signature: ______________ Date: ______________

Office Use Only Date received: ________ Int: ____
Date entered: _________ Int: ____

P.O. BOX 440021, TAMIAMI STATION, FL 33144 | Phone: 305.894.2387 | Fax: 305.894.1187