

Stockbridge-Munsee Health & Wellness Center

W12802 County Hwy A

Bowler, WI 54416

TEL: (715) 793-4144

FAX: (715) 793-4120

New Patient Registration and/or PRC update Form

Chart# _____

CONFIDENTIAL INFORMATION

Welcome to the Stockbridge-Munsee Health & Wellness 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): _____

Maiden/other names used: _____ Sex: Male Female

Race: _____

Date of Birth: _____ Social Security Number: _____

Marital Status (circle one): M S W D Spouse Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address (if different): _____

Date Moved to this address _____ Phone #: _____ Cell #: _____

Work #: _____

Employer Name: _____ Employer Address: _____

Employment Status (circle one): Full-Time Part-Time Unemployed

Tribe of Membership (You must provide proof): _____

Enrollment Number: _____

If not enrolled, then living descendant of which tribe? (You must provide written proof) _____

Do you have any children under the age of 18? Yes No

Are you a Veteran? Yes No

Who can we contact in case of an emergency?

Name: _____

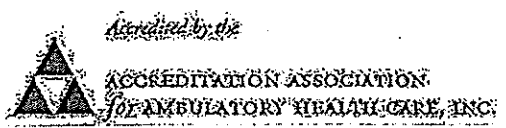
Relationship: _____ Address: _____

Phone: _____

Name of Nearest Relative: _____ Relationship: _____

Address: _____ Phone: _____

Initials _____





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PARENTAL/Legal Guardian INFORMATION: (Only if patient is under 18)

Father's Full Name: _____

Mother's Full Maiden Name: _____

Other Legal Guardian: _____

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 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 Number: _____ Effective Date: _____

Medicare Number: _____ A Only B Only A & B Eligible

Medicare A effective date: _____ Medicare B effective date: _____

SECONDARY 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

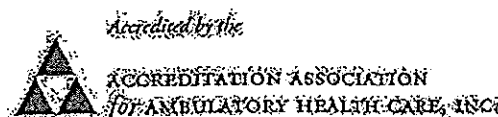
Effective Date: _____ Policy Holder's Name: _____

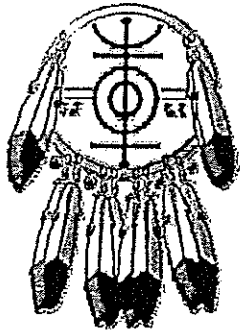
Address of Policy Holder: _____ Phone #: _____

Relationship to Patient: _____

Policy Holder's SS#: _____ DOB: _____ Sex: Male Female

Initials _____





Stockbridge-Munsee Health & Wellness Center

WI2802 County Hwy A

Bowler, WI 54416

TEL: (715) 793-4144

FAX: (715) 793-4120

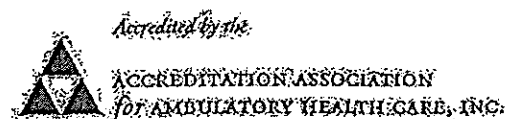
Authorization to furnish information and Assignment of benefits (Private Insurance, Medicare, and Medicaid)

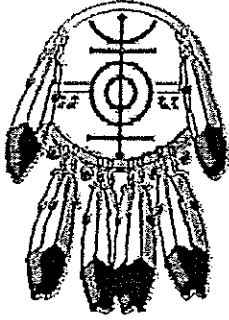
The Stockbridge-Munsee Health & Wellness Center may disclose all or any part of the patient's health record to any person or corporation which is or may be liable under a contract to a hospital, medical service company, insurance company, workers compensation, public aid funds, patient's employer, Medicare,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

I hereby assign to the Stockbridge-Munsee Health & Wellness 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 Stockbridge-Munsee Health & Wellness Center. I understand this assignment will remain in effect until revoked by me in writing. A scanned copy of this assignment is to be considered as valid as the original.

Patient Signature: _____ Date: _____

Initials _____





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Acknowledgement of Receipt of Notice of Privacy Practices

My signature on this form acknowledges that I have received a copy of the Stockbridge-Munsee Health and Wellness Center's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by the SMHWC 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 (State relationship to Patient) _____ Date
Or Witness (if signature is by thumb print or mark)

Signature of SMHWC staff member _____ Title _____ Date _____

TO BE COMPLETED BY SMHWC EMPLOYEE IF FORM IS NOT SIGNED

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

Signature of SMHWC staff member _____ Title _____ Date _____

Initials _____

