Teejuh
Behavioral Programs and Counseling Services

Patient Registration Worksheet

General Information

Note: Please fill in every blank or check every response. Use N/A if applicable.

H.R. #

Date

Month Day Year

Sex

- ○ Female
- ○ Male

Full Name *

First Name Middle Name Last Name

Other Names (Maiden, Former, Nickname, Etc.)

First Name Last Name

Date of Birth *

Month Day Year

Birth Place *

Social Security Number

Internet Access

- ○ Yes
- ○ No

Where do you have access?

- ○ Work
- ○ Home
- ○ Other

Current Physical Address *

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

When did you move to current address?

Month | Day | Year

Current Mailing Address: *

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Home Phone Number *

Please enter a valid phone number.

Cell Phone Number *

Please enter a valid phone number.

Native American Eligibility

Is Patient Alaskan Native or American Indian?

Race/Heritage:

- ○ Asian
- ○ African American
- ○ White
- ○ Other

Enrollment Number:

Blood Quantum:

Tribe: *

If Yes, Which Parent?

- ○ Mother
- ○ Father

Your Blood Quantum:

Are you from a Federally Recognized Tribe?

- ○ Yes
- ○ No

If Yes, which Tribe? *

Enrollment Number:

Do you have your enrollment information with you?

- ○ Yes
- ○ No

Advanced Directives/Power of Attorney

Do you have Advanced Directives?

- ○ Yes
- ○ No

Is there a copy on file with CAIHC?

- ○ Yes
- ○ No

Do you have a designated Power of Attorney?

- ○ Yes
- ○ No

Do you have a copy on file with CAIHC?

- ○ Yes
- ○ No

Married Status

Marital Status:

- ○ Married
- ○ Divorced
- ○ Seperated
- ○ Widowed
- ○ Life Partner
- ○ Single

Employment Information

Employment Status:

- ○ Full Time
- ○ Part Time
- ○ Unemployed
- ○ Full/Part Time Student
- ○ Self Employed
- ○ Retired

If Retired, Date of retirement:

Month Day Year

Employers Name:

Title/Position:

Employers Address:

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Work Phone:

Please enter a valid phone number.

Have you served in the Armed Forces?

- ○ Yes
- ○ No

If Yes, which Branch?

Do you have V.A. Benefits?

- ○ Yes
- ○ No

Guarantor Information

If patient is a minor, list who is responsible for this patient.

Relationship to Patient: (Use "self" if you are the patient) *

Social Security Number:

Gender: *

- ○ Male
- ○ Female
- ○ Other

Full Name: *

First Name | Middle Name | Last Name

Date of Birth: *

Month | Day | Year

Employer

Current Mailing Address: *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Home Phone: *

Please enter a valid phone number.

Cell Phone: *

Please enter a valid phone number.

****Important Note:** If I.H.S Beneficiary Patient ONLY, please refer to CAIHC's Health Benefits Specialist*****

Insurance Information

Primary Insurance:

Company Name: *

Insurance Company Phone number: *

Please enter a valid phone number.

Insurance Type:

- ○ PPO
- ○ HMO
- ○ Other

Coverage Type:

- ○ Single
- ○ Family

Insurance Source:

- ○ Employer
- ○ Group
- ○ Non-Group
- ○ Other

Group Number: *

Policy Number: *

BIN Number: *

PCN Number: *

Person Code:

Insurance Coverage Start Date *

Month Day Year

Insurance Coverage End Date *

Month Day Year

Services Covered:

- [ ] Medical
- [ ] Dental
- [ ] Vision
- [ ] Prescription

Policy Holders Name: *

First Name | Last Name

Primary Care Physician: *

First Name | Last Name

PCP Number: *

Policy Holder Address:

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Policy Holder's Gender: *

- ○ Female
- ○ Male

Policy Holders Date of Birth: *

Month | Day | Year

Policy Holders Social Security Number:

Do you have secondary insurance?

- ○ Yes
- ○ No

Do you have Medicare?

- ○ Yes
- ○ No

Do you have Medicaid?

- ○ Yes
- ○ No

Do you have Denali Kid?

- ○ Yes
- ○ No

Secondary Insurance:

Company Name:

Insurance Company Phone Number:

Please enter a valid phone number.

Insurance Type:

- PPO
- HMO
- Other

Coverage:

- Single
- Family

Source:

- Employer
- Group
- Non-Group
- Other

Group Number:

Policy Number:

BIN Number:

PCN Number:

Person Code:

Insurance Coverage Start Date:

Month Day Year

Insurance Coverage End Date:

Month Day Year

Services Covered:

- [ ] Medical
- [ ] Dental
- [ ] Vision
- [ ] Prescription

Policy Holders Name:

First Name Last Name

Primary Care Physician:

First Name

Last Name

PCP Number:

Policy Holders Address:

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Policy Holders Gender:

- ○ Female
- ○ Male

Policy Holders Date of Birth:

Month Day Year

Policy Holders Social Security Number:

Medicare Insurance:

Medicare:

- ○ Yes
- ○ No

Medicare Number:

Medicare Plan Number:

Prescription Plan Name:

Effective Date for Plan A:

Effective Date for Plan B:

Effective Date for Plan D:

Medicaid Insurance:

Medicaid:

- ○ Yes
- ○ No

Eligibility Dates:

Medicaid Number:

Designated Provider:

First Name | Last Name

Coverae Type:

- ○ Full
- ○ Basic

Denali Kid Care Insurance:

Denali Kid Care:

- ○ Yes
- ○ No

Eligibility Dates:

Denali Kid Care Number:

Designated Provider:

First Name Last Name

Coverage Type:

- ○ Full
- ○ Basic

Veteran Insurance:

Service Branch (Last):

Service Entry Date (Last):

Service Seperation Date (Last):

Vietnam Services Indicated?

Service Connected:

Claim Number:

Description of VA Disability:

Valid VA Card:

DD214 Available:

Emergency Contact Information:

Full Name: *

First Name Last Name

Phone Number *

Please enter a valid phone number.

Relationship: *

Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Additional Contact Information:

Do you have additional contact information?

Name *

First Name

Last Name

Phone Number *

Please enter a valid phone number.

Relationship: *

Address *

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Certification Statement:

I certify and attest that the information in this Patient Registration Worksheet is correct, to the best of my knowledge and belief. I understand that falsification of information may subject me to denial of CAIHC's Purchase Referred Care (PRC) Student Education Program. This Worksheet must be completed yearly or until the Student Education Program has been completed, and delivered to CAHIC's PRC Program.

Name

First Name | Last Name

Today's Date

Month Day Year