Indian Health Council
50100 Golsh Rd
Valley Center CA 92082
760-749-1410

Empowering Native Wellness

NEW PATIENT WELCOME LETTER

We at Indian Health Council, Inc. wish to take a moment to welcome you to our practice!

We want you to know that we appreciate the opportunity to take care of you and your family. Thank you for selecting us as your patient centered home and we look forward to serving you. Our goal is to provide you with the best coordinated, highest quality care. To reach this goal our skilled professionals take a personalized approach to care by sitting down with you and discussing your healthcare needs and treatment.

Your health is our primary concern. Our philosophy is to provide comprehensive care while treating every patient with dignity and respect. We treat a full spectrum of both acute illnesses and chronic conditions and offer a wide variety of services and preventive programs to address your physical, mental, and spiritual well being. ***"We Strive to Empower Native Wellness."*** In order to expedite the new patient registration process, we ask that you ***complete*** the following forms:

PATIENT REGISTRATION/INTAKE FORM

CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

FINANCIAL SCREENING FORM

MEDICAL HEALTH HISTORY (Child or Adult)

DENTAL PATIENT HEALTH HISTORY (Child or Adult)

OFFICE POLICY NOTICE TO PATIENTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF ADVANCE DIRECTIVE INFORMATION (18 OR OLDER)

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

In addition, to completing these forms, we ask that you ***read*** the documents containing information on IHC's **PRIVACY PRACTICES**, **ADVANCE DIRECTIVE INFORMATION** and our **DENTAL MATERIALS FACT SHEET**. Other information that is needed to determine your eligibility for services includes the following documentation to be ***brought into*** IHC to Central Registration:

- ☐ **PROOF OF INDIAN (*BIA Letter, Tribal ID Card or Tribal Letter)***
- ☐ **PROOF OF RESIDENCY (*Current Utility Bill, DMV Registration, Rental/Lease Agreement)***
- ☐ **INSURANCE CARD**
- ☐ **COPY OF SOCIAL SECURITY CARD**
- ☐ **MARRIAGE CERTIFICATE *(If Non-Indian Spouse)***
- ☐ **BIRTH CERTIFICATE *(If Child/Minor)***
- ☐ **PROOF OF INCOME *(If uninsured)***

Again, thank you for choosing us. We look forward to seeing you at the clinic and will do our best to make your visit as pleasant, efficient and complete as possible.

Sincerely,

Indian Health Council, Inc.

Empowering Native Wellness

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50100 Golsh Rd
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Chart # ______________

PATIENT REGISTRATION/INTAKE FORM

Patient's Legal Name: ____
Last First M.I. (Maiden)

Other Names Known by: ____

Home Address: ____
Street City State Zip

Mailing Address: ____
Street/PO Box City State Zip

Soc. Sec. # ________ - _____ - ________ Home Ph#: (   ) ____________________ Work Ph#: (   ) ____________________

Date of Birth: ______________________ Birthplace: ______________________________ Sex: F M

Marital Status: Single Married Child/Infant Spouse's Name: ______________________________

Ethnicity: American Indian Asian African American Filipino Hispanic
Caucasian Pacific Islander Other Non-Caucasian

Tribe: ____________________________________ Tribal Roll #: ______________________________

Occupation: ______________________________ Name of Employer: ______________________________

U.S. Veteran: Yes No Service Branch: ______________________________

Vietnam Vet: Yes No Separation Date: ______________________________

Father's Name: ______________________________ ____________________ ____________________
Father's Birthplace Father's Tribe

Mother's Maiden Name: ______________________ ____________________ ____________________
Mother's Birthplace Mother's Tribe

Person to Contact In Case of Emergency: ____
Name Relationship

____
Street City State Zip

____
Phone #

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Primary Medical Insurance	Secondary Medical Insurance
Insurance Carrier: ____________	____________
Carrier's Phone #: ____________	____________
Employer: ____________	____________
Policy #: ____________	____________
Group #: ____________	____________
Subscriber: ____________	____________
Relationship to Patient: ____________	____________

Primary Dental Insurance	Secondary Dental Insurance
Insurance Carrier: ____________	____________
Carrier's Phone #: ____________	____________
Employer: ____________	____________
Policy #: ____________	____________
Group #: ____________	____________
Subscriber: ____________	____________
Relationship to Patient: ____________	____________

If you are currently uninsured please complete the following:

Income Information: # of Persons in the Household 1 2 Adults
1 2 3 4 5 6 7 Children
Please check approximate Yearly Income:

0 - $10,000 $10,001- $25,000 $25,001- $40,000 $40,001- $55,000

$55,001-$65,000 over $65,000

Person responsible for payment: ____________________________
Name Relationship

____
Street City State Zip

Certification Statement: I certify that the information above is true and accurate to the best of my knowledge.

____
Name of Patient (Print)

____________________ ____________________
Name of Responsible Party (Print) Date

____________________ ____________________
Signature of Responsible Party Drivers License #

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50100 Golsh Rd
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Chart # _______________

Consent for Treatment & Assignment of Benefits

Clinic and Main Office
P.O. Box 406
Pauma Valley, CA 92061
(760) 749-1410

Santa Ysabel Satellite Clinic
P.O. Box 10
Santa Ysabel, CA 92070
(760) 765-1220

1. Consent to Medical, Dental, Psychological, Nursing and Surgical Procedures:
   The undersigned consents to the patient entering the Facility identified above and receiving medical, dental, psychological, general duty nursing or surgical procedures, which may include emergency services, laboratory procedures, x-ray examinations, anesthesia and other procedures under the general and specific instructions of the patient's healthcare provider(s). The undersigned acknowledges that the patient or the legal representative of the patient will be required to sign additional consent forms for complex treatments and procedures which require the patient's provider to obtain informed consent from the patient or the patient's legal representative for such treatment or procedures.

2. Release of Patient Information:
   The Facility will not release patient identifiable information to any third party without the patient's written consent, except as permitted or required by law: The undersigned agrees that the Facility may release information without a patient consent, to the extent necessary, (1) to insure continued treatment by healthcare providers and (2) to determine who is responsible for payment and to obtain payment or reimbursement for services provided to the patient; Third parties who may receive such information under this paragraph include insurance companies, utilization reviewers, case managers, federal and state agencies, consulting and treating providers, patient's employer and managed care plans who are responsible for payment of covered services. (Psychological/HIV/AIDS information will require a special consent prior to release).

3. Payment for services rendered:
   I, the undersigned, certify that the information given to the Facility in applying for payment by third parties is correct. I hereby authorize payment of benefits on my behalf for services furnished to me, and authorize the Facility to release minimum necessary patient health information pertaining to the visit to the Health Care Financing Administration or to the California Department of Health Services or other agents which is necessary to determine benefits or payment for services under these programs.

Patient's Name: ______________________________ DOB: ______________

Signature: ______________________________ Date: ______________
Patient/Legal Representative

Relationship to Patient: ______________________________

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FINANCIAL SCREENING FORM

CHART # ______________

Indian Health Council, Inc. is currently participating in the following programs: Healthy Family Program (HFP), Medi-Cal, County Medical Services (CMS) and Low Income Health Program (LIHP). Answer the following questions for yourself *OR* for the person being seen to determine which program is appropriate.

Patient Being Screened:	Age:	Phone:
Parent/Person Responsible:		Patient SSN:
Mailing Address:		Patient Birth date:

Number of Household Dependents: Adults _______ Children _______ Household Gross **Monthly** Income: $ ____________________

- ☐ I certify that the above Household Size and income declaration is true and correct. I agree to notify Indian Health Council of any changes.
- ☐ I do not wish to declare my household size and income and understand that it will affect the ability to determine my eligibility for publically Funded healthcare programs and for Contract Health Services benefits.

SIGNATURE: ____________________ **DATE:** __________

Are you INDIAN? ☐ Yes ☐ No	Are you a VETERAN? ☐ Yes ☐ No	Do you live in North San Diego County? ☐ Yes ☐ No	Which RESERVATION are you enrolled with?

Does the patient currently have any of the following? (✔ which apply):

☐ Healthy Families ☐ Medi-Cal ☐ Medicare ☐ CMS ☐ Private Health Insurance ☐ Dental Insurance

IF **YES** 1. List name of coverage: ______________________ 2. Policy Number: ____________________

3. Insurance Phone Number: (__) ______________________ 4. Coverage type: ☐ Medical ☐ Dental ☐ Vision

5. STOP HERE, AND RETURN TO THE RECEPTIONIST ALONG WITH YOUR CARD.

IF **NO**, PLEASE COMPLETE THE QUESTIONS, Numbers 1-14 BELOW.

YES	NO	QUESTION
		1. Are you the parent, legal guardian or caretaker relative (aunt, grandparent, etc.) Of a person under 21 living in your household?
		2. Are you unable to work due to a physical or mental illness, disability or handicap that is **EXPECTED TO LAST MORE THAN ONE**
		3. Do you currently receive Social Security or Supplemental Security Income Benefits?
		4. Have you been discontinued from Social Security or Supplemental Security Income Benefits? If YES, When? ____________ Why? ____________
		5. Is there a parent absent from the home or unemployed?
		6. Are you diabetic or have kidney failure?
		7. Are you pregnant?
		8. Have you been determined legally blind?
		9. Do you smoke or use smokeless tobacco?
		10. Does anyone in your household smoke or are you exposed to second hand smoke?
		11. Have you had a physical exam including rectal, pap and breast exam within the past year?
		12. Do you have a family history of Breast Cancer?
		13. Do you have a family history of Chronic Disease (High blood pressure, Diabetes, etc.)?
		STOP HERE

BELOW FOR IHC OFFICE USE ONLY

MEDI-CAL Eligible ☐ YES ☐ NO ☐ With NO SOC ☐ SOC: $ ________	CMS Eligible ☐ YES ☐ NO Eligibility Date:	HFP Eligible ☐ YES ☐ NO Eligibility Date: __________ EAPC Eligible ☐ YES ☐ NO Eligibility Date: __________
FAMILY PACT Eligible ☐ YES ☐ NO Eligibility Date:	CDP Eligible ☐ YES ☐ NO Eligibility Date:	REFERRAL MADE ☐ MC ☐ CMS ☐ EAPC ☐ HFP ☐ CONTRACT CARE ☐ MEDICARE ☐ OTHER
Signature:		Date:

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

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Chart # ___________

MEDICAL PATIENT/HEALTH HISTORY (CHILD-Age < 19)

Name of Patient: ____
Last Name First Name Middle Initial

Sex: ☐ Male ☐ Female Age: ______ Birth date: ______ Nickname: ____________________

What is the name of your child's medical doctor? ______________________________

Has there been any change in your child's general health this past year? Yes ☐ No ☐

If yes, please describe the changes: ______________________________

List any medications (pills or drugs) that your child is currently taking: ______________________

List any other medications your child has taken in the last two months: ______________________

Is your child allergic to anything? Yes ☐ No ☐ If yes, please list drug(s) and reactions(s): ______________

Past Medical History

Does your child have any current chronic illnesses such as: Diabetes, Hypertension, Heart Disease, Asthma, ADD/ADHD, etc.?

☐ No ☐ Yes, please list: ______________________________

____

____

____

Has your child had any prior serious illness or surgeries? ☐ No ☐ Yes, please list including dates if known:

____

____

____

Has your child ever been hospitalized? ☐ No ☐ Yes, please explain: ______________________

____

____

____

Has your child ever had any surgeries? ☐ No ☐ Yes, please explain: ______________________

____

____

Is your child being treated by a physician now? ☐ Yes ☐ No

Date of your child's last medical exam: Month Day Year ☐☐☐☐☐☐☐☐ ☐ None

Reason for exam: ______________________

Is your child being treated by a dentist now? ☐ Yes ☐ No

Date of your child's last dental exam: Month Day Year ☐☐☐☐☐☐☐☐ ☐ None

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Family History (Check all that apply):

Please indicate if your mother, father or sibling has any of the following diseases now or if it was their cause of death (COD).

	Mother Now	Mother COD	Father Now	Father COD	Sister(s) Now	Sister(s) COD	Brother(s) Now	Brother(s) COD
CVA (stroke)								
Diabetes								
Heart disease								
Heart disease before 60								
Heart failure								
High blood pressure								
High cholesterol								
Renal disease								

Please indicate if your mother, father or sibling has had any of the following diseases:

	Mother Now	Mother COD	Father Now	Father COD	Sister(s) Now	Sister(s) COD	Brother(s) Now	Brother(s) COD
Alcoholism								
Allergies								
Alzheimer's disease								
Asthma								
Blood disease								
Cancer								
Circulation Problems								
Depression								
Development delay								
Eczema								
Irritable bowel disease								
Learning disability								
Mental Illness								
Migraines								
Obesity								
Seizure disorder								
Other family history:								

Immunizations (Approximate dates are fine):

Date of last flu shot? ___________ ☐ None   Date of last pneumonia shot: _____________ ☐ None

Date of last tetanus shot: ____________ ☐ None

Social History (Check all that apply):

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner

Language: ☐ English ☐ Spanish ☐ Chinese ☐ French Other: __________

Ethnicity: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian Other: __________

☐ Native American: Tribe ________________

Who lives at home?

Name:	Age:	Relationship:		Name:	Age:	Relationship:

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Social History (ALL AGES): Cont'd

Mother's Occupation: ______________________________

Father's Occupation: ______________________________

Are there any occupational hazards at your place of employment such as: asbestos, chemicals, excessive noise, potentially toxic fumes? ☐ No ☐ Yes, please list: ______________

Any concerns about lead exposure? ☐ No ☐ Yes

Water source: ☐ Municipal ☐ Well Is water fluoridated? ☐ No ☐ Yes

Tobacco Exposure: Are there smokers in the home? ☐ No ☐ Yes

If yes, amount of exposure: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Child Care? ☐ No Yes If so how many hours per week? ______________

Social History (BIRTH TO ONE YEAR):

Sleep:	Yes	No		Safety:	Yes	No
Takes Naps:				Car restraints:		
Nightmares/sleep problems:				Carbon monoxide detector:		
Sleeps with parents:				Smoke detectors:		
Sleeps through the night:				Pets/animals at home:		
Minimum 8.5 hrs sleep nightly:						

Sleep position: ☐ Back ☐ Abdomen Car restraints: Front facing: ☐ None: ☐

# of firearms: ☐ Locked Storage: ☐ No ☐ Yes Rear facing: ☐

Social History (1 YEAR TO <5 YEARS):

Sleep:	Yes	No		Safety:	Yes	No
Takes Naps:				Uses bike/skating helmet:		
Nightmares/sleep problems:				Car restraints:		
Sleeps with parents:				Carbon monoxide detector:		
Sleeps through the night:				Smoke detectors:		
Minimum 8.5 hrs sleep nightly:				Pets/animals at home:		

Concerns: ______________ Relationship with sibling(s): ______________

Activity: Exercise/sports ☐ hours per day TV/Computer games ☐ hours per day

Hand Dominance: ☐ Right ☐ Left

Education:		
School Name:		
Grade level in School:		
	Yes	No
Learning Disability?		
Special Needs?		

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Social History (5 YEARS TO <11 YEARS):

Sleep:	Yes	No	Safety:	Yes	No
Takes Naps:			Uses bike/skating helmet:		
Nightmares/sleep problems:			Car restraints:		
Sleeps with parents:			Carbon monoxide detector:		
Sleeps through the night:			Smoke detectors:		
Minimum 8.5 hrs sleep nightly:			Pets/animals at home:		

Sleep position: ☐ Back ☐ Abdomen Car restraints: Front facing: ☐ None: ☐

Of Firearms: ☐ Locked Storage: ☐ No ☐ Yes Hand Dominance: ☐ Right ☐ Left

Relationships:	Yes	No	Education:	Yes	No
Cooperates w/family, friends:			School name:		
Cooperates with teachers:			Grade in school:		
Has enough friends:			Grades earned:		
Has friends of both sexes:			Gifted program:		
Concerns about relationship w/family, friends, others:			Learning disability:		
			Special Needs:		

Concerns: ______________________ Relationship with sibling(s): ______________________

Activity: Exercise/sports ☐ hours per day TV/Computer games ☐ hours per day

Social History (11 YEARS TO <19 YEARS):

Sleep:	Yes	No	Safety:	Yes	No
Minimum 8.5 hrs sleep nightly:			Uses bike/skating helmet:		
Nightmares/sleep problems:			Car restraints:		
Alcohol Use:			Carbon monoxide detector:		
Frequency: ☐ Daily ☐ Weekly ☐ Monthly			Smoke detectors:		
☐ Occasionally ☐ Rarely			Pets/animals at home:		

Concerns: ______________________ Relationship with sibling(s): ______________________

Activity: Exercise/sports ☐ hours per day TV/Computer games ☐ hours per day

Hand Dominance: ☐ Right ☐ Left

Relationships:	Yes	No	Education:	Yes	No
Cooperates w/family, friends:			School name:		
Cooperates with teachers:			Grade in school:		
Has enough friends:			Grades earned:		
Has friends of both sexes:			Gifted program:		
Concerns about relationship w/family, friends, others:			Learning disability:		
			Special Needs:		

The information I have given is correct and to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

______________________________ ______________________

Signature of Parent/Guardian *Date*

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Chart # ___________________

Dental Patient/ Health History (Child)

Name of Minor/Child: ____
Last Name First Name Middle Initial

Sex: M ☐ F ☐ Age: _______ Birth date: ___________ Nickname: _______________ Hobbies: _______________________

MEDICAL HISTORY

Minor/Child's Physician: ______________________________ City/State: _____________________________ Phone: ___________________________

Date of last physical examination: ______________________ Results: ____

Has your child received medical treatment within the last six months? ___________ Reason: ____

Does your child have a heart condition or heart murmur? _________ Explain: ____

Have you ever been told that your child should have antibiotics before all dental appointments? ____

Has your child ever been hospitalized? ___________ Date: ______________ Reason: ____

Has your child ever had a serious illness or operation? ___________ Please List: ____

Has your child had a blood transfusion or received any clotting agents? _______ Date: ___________ Reason: _______________________________

Does either your family or your child have a history of complication from general anesthesia? ____

If so, what type? ____

Is your child taking any medications? __________ If yes, what? ____

____

Does your child have any allergies? __________ If yes, to what? ____

____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK ☑

☐ A.I.D.S.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Seizures/Convulsions	☐ Hearing Problems	☐ Latex Allergy	☐ Bleeding Tendencies
☐ Bladder Problems	☐ Diabetes	☐ Alcohol/Drug Abuse	☐ Mumps	☐ Hepatitis
☐ Cancer	☐ Heart Problems/Murmur	☐ Congenital (Born with) Heart Problems		

DENTAL HISTORY

Date of last Visit to a dentist: ____ For what service? ____

	Yes	No		Yes	No
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc…? Yes ☐ No ☐

The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

______________________________ ______________________________
Signature of Parent/Guardian Date

FOR OFFICE USE ONLY

NOTES: (For Dental Staff) ____________________________ For Office Use Only: Date: _____________ Reviewer: ______________

____ _____________ ______________

____ _____________ ______________

____ _____________ ______________

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OFFICE POLICY NOTICE TO PATIENTS

We strive to provide you the best personalized care available. To make this possible, we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

☐ **Late Policy**

Medical Department: Being late more than five (5) minutes for a short appointment or ten (10) minutes for a long appointment will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations or no-shows are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

Dental Department: Being late more than five (5) minutes for an appointment that is shorter than one hour or fifteen (15) minutes for an appointment greater than or equal to one hour will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations or no-shows are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **Twenty-Four Hour Advance Notice**

If you wish to change or cancel an appointment we would like a 24-hour advance notice. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **No-shows are bad**

If you fail to show for an appointment without notice, that is considered a no-show. The dental department adheres to a strict policy stating that after 3 broken appointments, a patient will have all future appointments removed and will not be rescheduled for a year and will only be seen on a "first come, first served basis."

☐ **Missing Indian Verification**

Native Americans coming into the clinic without their BIA or tribal affiliation will be seen one time free of charge and will be required to complete a "One Time Only Visit" form.

☐ **Eligibility for Healthcare services does not mean services are free of charge**

Fees for services and responsibility for payment are based on the patient's eligibility for care according to the following categories: CHS Native, Direct Native and Non-Native and as governed by federal laws and regulations.

☐ **Specialty Copayments are due at the time of service**

Direct Natives without insurance are required to pay a $20 copayment at the time of service for the following specialty services: Acupuncture, cardiology, chiropractic, podiatry, orthopedics, and ophthalmology. In addition uninsured Direct Natives are responsible for copayments for major dental work and shall be given a treatment estimate in advance of work being performed.

☐ **Financial Hardship**

If you are experiencing financial difficulties and are unable to afford the cost of our services we offer discounts based on a sliding fee scale set in accordance with federal poverty guidelines according to household size and income. Proof of income is required to access discounts.

☐ **Cell phones must be shut OFF or silent**

We realize emergencies may arise and allow you to have your phone with you during your appointment however please it set to silent mode or have it turned off so as not to interrupt your time with your provider and to maximize your quality of care.

Signature: ______________________________ Date: ______________

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Chart # ________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the Indian Health Council (IHC) Notice of Privacy Practices at:

Indian Health Council, Inc.
50100 Golsh Road
Valley Center, CA 92082

______________________________________ ____________________
Patients Name (Print) Date of Birth

______________________________________ ____________________
Signature of Patient Date

______________________________________ ____________________
Signature of Patient Representative Date
(State Relations to Patient)
Or witness (if signature is by thumb print or mark)

______________________________________ ____________________
Signature and title of IHC Employee Date

For Patients Unable to Acknowledge Receipt
I hereby certify that the patient was unable to acknowledge receipt of the IHC notice of Practices because:

____

______________________________________ ____________________
Signature of IHC Staff Date

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Chart # ________________

ACKNOWLEDGEMENT OF RECEIPT OF
Dental Materials Fact Sheets

"I, ______________________________ acknowledge I have received from Indian Health Council, Inc. a copy of the Dental Materials Fact Sheet dated May 2004, as required by law."

______________________________	______________________________
Patient Name (Print)	Patient's Date of Birth
______________________________	______________________________
Signature of Patient/Parent/Guardian	Date
______________________________	______________________________
Signature and title of IHC Employee	Date

<u>For Patients Unable to Acknowledge Receipt</u>

I hereby certify that the patient was unable to acknowledge receipt of "Dental Materials Fact Sheet" packet because:

____
____
____
____

______________________________	______________________________
Signature of IHC Staff	Date