MISSOULA URBAN INDIAN HEALTH CENTER
406.829.9515
830 West Central, Missoula MT 59801
www.micmt.com

Welcome to Missoula Urban Indian Health Center

Let us help you with registration. Please review the required documentation for services**.** Inform us if you have any questions. We are happy to assist you.

Missoula Urban Indian Health Center required documents include:

	Date Rcv'd / Initials
• Proof of Tribal Enrollment **or** Descendancy (up to 2nd degree)	
• Photo ID (i.e. Valid Driver's License, State ID, etc.)	
• Insurance Information (Private, Medicare, Medicaid, etc.)	
• Release of Information/Assignment of Benefits *(if applicable)*	
• Proof of Residency, within Missoula Urban Area (1 official form required)	
• Notice of Privacy Practices Acknowledgement	
• MUIHC Registration Form (completed)	

Additional documents required for **Confederated Salish-Kootenai Tribes-Tribal Health & Human Services** Registration include:

- Social Security Card
- Birth Certificate
- Proof of Residency (2nd form required for THHS)
- CSKT THHS Registration Forms (completed entirely)

A staff member will review information, to verify MUIHC Registration is complete. Thank you.

Initials of Screener:
Date:

MISSOULA URBAN INDIAN HEALTH CENTER PATIENT REGISTRATION FORM

RPMS #

Patient's Legal Name: _____
Last *First* *Full middle name*

[ ] DIVORCED
[ ] MARRIED (Common Law)
[ ] NEVER MARRIED
[ ] SEPERATED
[ ] SINGLE
[ ] WIDOW(ER)

Sex: [ ] M [ ] F Social Security Number: _____-_____-_____ Marital Status:

[ ] Address: _____ _____ _____ _____
Physical Street Address or PO Box *City* *State* *Zip*

Birth date: ____/____/____ City & State of Birth: _____ When did you move here? ____/____

[ ] Phone: [ ]( ) _____ [ ]( ) _____ [ ]( ) _____
Home *Work* *Cell/Message*

[ ] E-MAIL Address: _____ @ _____
We may use your Email address to send you announcements of events you may have an interest in or when attempts to reach you by phone or postal mail have failed. **PLEASE CHECK PREFERRED METHOD OF CONTACT.**

IF PATIENT IS UNDER AGE 18:

Guardian: _____ *Relationship to Patient:*_____

Address (if different): _____
City *State* *Zip*

Telephone: ( ) _____ ( ) _____ ( ) _____
Home *Work* *Cell/Message*

Father's Employer: _____ *Mother's Employer:* _____

If you are a member of a Native American or Alaska Native Tribe, please provide the name of the tribe and a copy of your membership documentation. **Tribe:** _____ **Enrollment #:** _____ **Quantum:** _____

What is your Religious Preference? _____

Fathers Name: _____ Mothers Maiden Name: _____
Last *First* *Last* *First*

Fathers City/State of Birth: _____ Mothers City/State of Birth: _____

Employer: _____ **Status:** [ ] FT [ ] PT Other: _____
Company *Address* *City* *State/Zip*

Emergency Contact: Name: _____ Phone: _____

Address: _____ City: _____ State/Zip: _____

Relationship to patient: _____

Next of Kin: Name: _____ Phone: _____

Address: _____ City: _____ State/Zip: _____

Relationship to patient: _____

RPMS #

MISSOULA URBAN INDIAN HEALTH CENTER PATIENT REGISTRATION FORM

As a Federally Qualified Health Center and to keep our services affordable, we receive grant funding. To qualify for these resources we must collect the following information on all our clients. Please support us by answering all these questions.

Financial Responsibility: Do you have Insurance? [ ] Yes [ ] No **(Please check all that apply)**
[ ] Private [ ] Medicare [ ] Medicaid [ ] Dental [ ] Optical [ ] Prescription [ ] CHS-Tribe: _____
If you are a dependent on someone else's Insurance we will need the following to verify eligibility and bill the Insurance.

_____ _____ _____
Policy Holder's Full Name / Relationship to Patient | Date of Birth | Sex

***Be sure to provide the card(s) so we may make a photocopy*.**

Are you a US Veteran? [ ] Y [ ] N Do you have VA benefits? [ ] Y [ ] N Are you Service Connected? [ ] Y [ ] N

Branch: _____ Discharge Date: _____/_____/_____

Do you have an Advance Directive? [ ] Y [ ] N ***If YES***, is it a *(please circle)* Living Will or Power of Attorney or 5 Wishes

Indicate your ethnicity:
[ ] Not Hispanic or Latino [ ] Hispanic or Latino [ ] Unknown

Indicate your race(s):
[ ] American Indian/Alaska Native [ ] Asian [ ] Black or African American
[ ] Declined to Answer [ ] Native Hawaiian or Pacific Islander
[ ] Unknown [ ] White

What is your primary language you speak? _____What other languages do you speak? _____

Do you need an interpreter? [ ] Y [ ] N What is your preferred language? _____

Are you a migrant agricultural worker? [ ] Y [ ] N Are you a seasonal agricultural worker? [ ] Y [ ] N

Are you currently homeless? [ ] Y [ ] N ***If yes***, please, indicate if you are:
[ ] Staying in a shelter [ ] In a transitional living arrangement [ ] Doubling Up [ ] Living on the street

Do you have Internet Access? [ ] Y [ ] N ***If yes***, where? Home/ Work/ School/ Clinic/ Library/ Community Center

Income Information:

Number in Family _____Monthly Income $_____ **or** Annual Income $_____

Release of Information / Assignment of Benefits: MUIHC has my permission to release information, as needed, for insurance processing and for my Insurance to release payment to MUIHC. Furthermore, I accept financial responsibility for services provided to me according to the fees established. I understand and agree to provide MUIHC with information of any change in my household income or insurance status.

I certify the above information is accurate, to the best of my knowledge. I HEARBY AUTHORIZE TREATMENT.

Signature of Patient or Guardian: _____ Date: _____

Printed Name: _____

***Present: Photo identification, Proof of Tribal Enrollment, & Insurance Card(s)*.**

Initials of Screener

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a photocopy of the Notice of Privacy Practices from Missoula Urban Indian Health Center, which provides a description of uses and disclosures of Protected Health Information.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian/Legal Representative Relationship to Client

_____
Date

_____ _____
MIC Staff Signature Date

RPMS #:

Patient DOB: