Feather River Tribal Health, Inc.

Sponsoring Tribes: Berry Creek Rancheria, Mooretown Rancheria & Enterprise Rancheria

OROVILLE CLINIC ● (530) 534-5394
2145 5th Avenue ● Oroville CA 95965

YUBA CITY CLINIC ● (530) 751-8454
555 West Onstott Road ● Yuba City CA 95993

ADULT PACKET

Age 13 and up

PLEASE TAKE a copy of the Patient Hand Book and one of the Privacy Act (one per family of each)

For Native registration you will need:

1. **Picture ID**
2. **Indian Verification – CDIB (Certificate Degree of Indian Blood) card or letter from the BIA (Bureau of Indian Affairs), letter from Tribe or California Judgment Roll. Certified birth certificate (hospital birth announcements not accepted), if applicable. Marriage license, if applicable.**
3. **Medical and Dental Insurance, Medi-Cal, CMSP or Covered CA cards (we need to make a copy of all insurance cards).**
4. **18 years old and under must provide Immunization records.**

For Non-Native registration you will need:

1. **Picture ID**
2. **Medical and Dental Insurance, Medi-Cal, CMSP or Covered CA cards (we need to make a copy of all insurance cards).**
3. **All Non-Native's have to go through a screening process. During this process if you have an emergency please go to the nearest Emergency Room. Call the number below to check status of your registration.**
4. **FRTH does not accept Medical discount cards.**
5. **18 years old and under must provide Immunization records.**

We DO NOT ACCEPT incomplete registration packets.

PLEASE NOTE: If you haven't been seen in 3 years after you have registered your file will be inactivated. BEFORE you can make an appointment you must be seen in Registration. Non-Native patient's application will go through a screen process for approval.

Mikki Registration Clerk
530-534-5394 x 228 Fax 533-1113

Rev 10/2016 - 2019

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MEDI-CAL PATIENTS

The following information is for **all patients** that have Managed Care Medi-Cal – either:
CA Health & Wellness or Anthem Blue Cross

This information will affect you as a patient as a new patient and an established patient. The following process must be followed to become a patient here or continue to be an established patient at Feather River Tribal Health.

PROCESS TO BE FOLLOWED

NEW PATIENTS:

1. Submit a completed New Patient packet. Incomplete packets will not be accepted.

2. All new Non-Native patients will go through a screening process for approval.

3. Once your application has been approved you will need to do the following before an appointment can be made.
   a. Check your insurance card to see who is listed as your PCP (Primary Care Provider – i.e. Clinic or Doctor). **Do not change this prior to being accepted as a patient here at FRTH**.
   b. If your PCP is Feather River Tribal Health you won't need to change anything. If FRTH is not listed as your PCP you will be required to call and change the PCP to FRTH. You will then need to provide proof to FRTH by providing the reference number given to you at the time of your call. You will have 30 days to provide this proof to the clinic. **After 30 days the registration packet will no longer be valid and will be shredded.**

4. Newborns are covered under their mother for 30 days. The mother must have FRTH as their Primary Care Provider (PCP) prior to making an appointment for a newborn. After the 30 days the newborn must have their own insurance card and FRTH must be listed as their PCP.

ESTABLISHSED PATIENTS:

1. Check your insurance card to see who is listed as your PCP (Primary Care Provider – i.e. Clinic or Doctor).

2. If your PCP is Feather River Tribal Health you won't need to change anything. If FRTH is not listed as your PCP you will be required to call and change the PCP to FRTH. You will need to provide proof to FRTH by providing the reference number given to you at the time of your call. You will have 30 days to provide this proof to the clinic. **After 30 days the registration packet will no longer be valid and will be shredded.**

ESTABLISHED PATIENTS WITH PRC:

1. For you to continue on PRC FRTH must be listed as your PCP. Until this is done it will affect the following: Pharmacy, Medical Referrals (previously approved and those pending), Lab work, ER visits and Dental Referrals (preciously approved and those pending).

a. How it will affect your Pharmacy use: You will be required to pay for your prescriptions or go to another Pharmacy. PRC will not pay for it.
b. How it will affect Referrals: You will need to go to your PCP listed on your ID card to get a referral for Medi-Cal to pay for it.
c. How it will affect ER visits. If FRTH is not listed as your PCP and you have a Share of Cost (SOC) you will be required to pay that SOC. If you are given a prescription you will need to go to another Pharmacy to get it filled.
d. Medications from another Provider – You will have 30 days to change your PCP to FRTH to continue to get them filled here at our pharmacy. The only exception will be if it is ordered by a Provider that you were referred to from one of our Providers.

2. PLEASE NOTE: PRC is not retroactive. If you incur a cost prior to changing your PCP to FRTH it will not be covered.

3. In order for new PRC patient to be eligible for this program they must have FRTH as their PCP. To be eligible you must call your insurance (CA Health & Wellness or Anthem Blue Cross) and get a reference number as proof that your PCP has been changed. You then need to call Registration with the number so the change can be verified. You will then need to do the paperwork for PRC.

ANTHEM BLUE CROSS – CARD EXAMPLE

Front:	Back:
• Name • Member ID • Group No. • BIN • PCN • RxGrp • Coverage Code • PCP (Primary Care Provider) • PCP Address & Phone • Member Effective Date • Plan Code PCP Effective Date	• Important Member Phone Numbers 1-800-227-3238 PLEASE **NOT DO** NOT CHANGE YOUR PCP PRIOR TO BEING APPROVED AS A PATIENT. **After approval** call to change your PCP to: Feather River Tribal Health - Our PCP (Clinic) Number is: Z7N000 (Oroville clinic) and Z5I000 (Yuba City clinic)

CALIFORNIA HEALTH & WELLNESS – CARD EXAMPLE

Front:	Back:
• Name • Medi-Cal ID# • PCP Name (Primary Care Provider) • PCP Phone Number • PCP Effective Date • Pharmacy Vendor Information	• Important Member & Provider Phone Numbers 1-877-658-0305 • Paper Medical Claims Address • Website address PLEASE **NOT DO** NOT CHANGE YOUR PCP PRIOR TO BEING APPROVED AS A PATIENT. **After approval** call to change your PCP to: Feather River Tribal Health Our PCP (Clinic) Number is: 1629130240 (Oroville clinic) and 1588826374 (Yuba City clinic)

REGISTRATION FORM

Scanned Date:_____ Initials:____ RPMS NUMBER:_____ NG# | | | | | |

CLIENT COMPLETES QUESTIONS

DEMOGRAPHICS

Prefix Last First Middle Suffix Previous Last Nickname

Name:

Social Security	Date of Birth	Age	SEX (Check one) ❑ Male ❑ Female ❑ None ❑ Undifferentiated ❑ Unknown

Mailing / Billing Address:_____
Street City State Zip

Address Type: ❑Home ❑Mailing ❑Temporary
Country: ❑USA ❑Other:_____ **County**: ❑Butte ❑Yuba ❑Sutter ❑ Other (list):_____

Secondary Address:_____
Street City State Zip

Address Type: ❑Home ❑Mailing ❑Temporary
Country: ❑USA ❑ Other:_____ County: ❑Butte ❑Yuba ❑Sutter ❑ Other (list):_____

Mother's Maiden Name:_____

INFORMATION NEEDED FOR MINORS AND INSURANCE

Father's Last First MI	**Mother's** Last First MI
Name:_____	Name:_____
Phone: ( ) DOB:	Phone: ( ) DOB:

Contact Preference: ❑None ❑Cell Phone ❑Confidential ❑Don't call home number ❑Don't call work number ❑Don't leave a message ❑Home Phone ❑Okay to leave message ❑Other ❑Work Phone
EXCEPTION: In the case of an urgent situation, Feather River Tribal Health will attempt to contact you.

Notifications: *Please mark only one.* ❑Phone Call ❑Voice reminders (automated call) ❑Text ❑Opt out

Home Phone: ( )_____ Day/Work Phone: ( )_____ Ext____

Cell Phone: ( )_____ Alternate/Message Phone: ( )_____

Marital Status: ❑Married ❑Single ❑Common Law ❑Divorced ❑Domestic/Life Partner ❑Legally Separated ❑ Widowed

Smoker: ❑Yes ❑No **Family Information:** Family Size:_____ Annual Income: $_____

Language Barrier: ❑Yes ❑No **Interpreter Needed?** ❑Yes ❑No ❑Sign Language

Signature:_____ Printed Name:_____ DOB:_____

Employer Name:_____ Phone: (___)_____

Address:_____City:_____State:_____Zip:_____

County:_____ Occupation:_____ ❑Unemployed ❑Retired

Student Status: ❑Not a Student ❑Full Time Student ❑Part Time Student
School Based Health Center: ❑Yes ❑No

Is Patient a Minor: ❑Yes ❑No **If yes, Relationship To Minor:** ❑Adopted Child ❑Brother ❑Father ❑Foster Child ❑Friend ❑Grandchild ❑Guardian ❑Mother ❑Natural Child ❑Nephew/Niece ❑None ❑Parent, child is the patient ❑Sibling ❑Significant Other ❑Sister ❑Step child ❑Other_____

Race:
❑American Indian/Alaska Native ❑White ❑Asian ❑Black/African American ❑Declined to specify
❑Native Hawaiian/Other Pacific Islander ❑ Other:_____

Preferred Language:
❑English ❑Spanish/Castilian ❑Other:_____

Religion:
❑None ❑Assembly of God ❑Christian ❑Catholic ❑Interdenominational ❑Jehovah's Witness ❑Latter Day Saint ❑Mormon ❑Nazarene ❑Pentecostal ❑Protestant ❑Seventh Day Adventist ❑Other_____

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Declined to Answer ❑Unknown/Not Reported

Homeless Status:
❑Homeless ❑Not Homeless ❑Doubling Up ❑Shelter ❑Street ❑Transitional ❑Unknown/Unreported

Migrant Worker Status: ❑Not a farm worker ❑Migrant ❑Seasonal

If you are Native American, please fill out the following:

Tribe:_____Blood Quantum/Degree:_____Roll#:_____

Rancheria/Reservation:_____ Tribal Roll#:_____

NOTE: You must provide Indian Verification when you register as a patient. Examples of proof: CDIB card (Certified Degree of Indian Blood, Tribal card, be listed on the California Judgment Roll, Dawes Roll or be a Descendent (must use Certified Birth Certificates or Death Certificate to link to the Descendent).

Blood Quantum (for Native American only)
❑None ❑Full ❑Greater than or Equal to ½ but less than full half ❑Greater than or Equal to ¼ but less than full half ❑Indian but less than ¼ ❑Non Indian ❑Unspecified

Primary Medical Coverage: ❑Self Pay – Cash (No insurance) ☐ Native American (No Insurance)
Type of Insurance (please check all that apply):
❑Medicare (❑A ❑B ❑C ❑D) ❑Medi-Cal -- ❑CA Health & Wellness ❑Anthem Blue Cross ❑CMSP
❑Private Ins ❑Dental Ins ❑Prescription ❑Other:_____

Public Housing Primary Care: ❑None ❑Other ❑Public Housing

Veteran Status: ❑Yes ❑No ❑Not collected yet ❑Other:_____

Signature:_____ Printed Name:_____ DOB:_____

Feather River Tribal Health, Inc.

AUTHORIZATION TO BILL & TREAT

Patient Name: _____ Birth Sex: ❑ Male ❑ Female ❑Undifferentiated ❑ None
Current Gender: ❑ Male ❑ Female ❑Undifferentiated ❑ None

Home Address: _____ Date of Birth: _____

_____ Social Security #: _____

City/State/Zip: _____ Day Phone: _____

Mailing Address: _____ Cell Phone: _____

City/State/Zip: _____ Other/Message Phone: _____

- I authorize, to the extent permitted under applicable law, the release of any information necessary to process claims for payment on my behalf. I also authorize any third party payments to be sent payable to Feather River Tribal Health, Inc.
- I authorize Feather River Tribal Health, Inc. to deposit checks received on account from my Insurance Company, when made out in my name.
- I understand that I am responsible for any balance not covered by a third party.
- I understand that it is my responsibility to pay co-payments at time of visit if applicable.
- This authorization for billing will remain in effect for one (1) year unless revoked by me in writing.
- Feather River Tribal Health, Inc. has my permission to provide routine and emergency medical care for myself or the minor child listed above.
- PLEASE NOTE: This includes **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**. I hereby acknowledge receipt of Feather River Tribal Health (FRTH) Notice of Privacy Practices upon registration. An additional copy is available upon request.

Print Name of Responsible Party: **X** _____

Patient Signature: **X** _____ **Date:** _____

(Parent or Guardian if Patient is a Minor)

FAMILY INFORMATION: Family size: _____ **Annual Income: $** _____

EMERGENCY CONTACT – Must be completed

Name: _____ Relationship: _____

Address: _____ Phone: _____

City/State/Zip: _____ Cell: _____

MINOR CONSENTS ONLY

Print Name of Parent/Guardian: _____

Relationship to minor (check one): ❑ Parent ❑ Guardian ❑ Other _____

NOTE: If signed by other than parent, a copy of guardianship papers or legal consent to obtain treatment must be attached.

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FEATHER RIVER TRIBAL HEALTH

Additional Patient Data

Patient Name:_____ Date of Birth:_____
(Please print)

1. Why do you want to be a patient of Feather River Tribal Health?_____
   _____
   _____
   _____
2. Who was your previous Provider (Doctor, FNP, PA, Clinic)?_____
   _____
   _____
3. Why are you changing providers?_____
   _____
   _____
   _____
4. Total number in Household:_____
5. Total Household Income: $_____ per year
6. Have you been displaced due to fire? ❑Yes ❑No Incident:_____
7. Did you lose your home? ❑Yes ❑No Location:_____

PATIENT HANDBOOK
ACKNOWLEDGEMENT OF RECEIPT

Attached is a copy of the Patient Handbook for Feather River Tribal Health, Inc. This handbook outlines the guidelines for services provided by our healthcare facilities as well as provides information about the organization.

It is the responsibility of the Feather River Tribal Health to provide this information to the patient. It is the responsibility of the patient to acknowledge receipt of the handbook and agree to comply with the guidelines as they are outlined.

By signing this acknowledgment, the patient acknowledges receipt of this patient handbook and the information that it contains.

Patient Signature:_____ **Date**:_____

Printed Name:_____

NAME _____DOB _____ MR# _____

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CURES AUTHORIZATION

At Feather River Tribal Health, our goal is to provide you with the highest quality care; therefore prior to establishing with us, we need to:

1. **Obtain your medical records from your previous healthcare provider prior to establishing care with FRTH.**

2. **Access your record of Controlled Prescriptions Medications by running a report from the State of California Controlled Medication Database, or CURES**

   - In order to expedite the new patient registration process, we ask that you complete the attached **Authorization for Release of Health Information THOROUGHLY**. Incomplete information may delay the processing of your registration.
   - Your previous provider may charge for copies of your records. **PLEASE NOTE**: FRTH will notify you if your previous provider requires a medical record processing fee which you are responsible for.

State of California Controlled Medication Database (CURES)

Your signature below grants Feather River Tribal Health permission to run a CURES Report; **you are not obligated** to authorize to this request, however you may not be considered eligible to establish care with FRTH without a CURES Report.
PLEASE NOTE: As with any of your private health information, we are mandated by law to maintain you privacy and confidentiality. Only staff with appropriate Permission may view this report.

Date:_____

Signature: _____ Print Name:_____

Witness Name: _____ Signature:_____

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CONSENT TO DISCUSS HEALTH ISSUES

Patient or Minor Name:_____ DOB:_____

❑ I **decline** for FRTH to discuss my health care issues.

❑ I **give my permission** to FRTH to discuss my health care issues with the following:

Name	Relationship	Phone/Cell Number

This form is ***not*** a release of records. This form will be used for discussion only and applies to the following departments (**must initial to be valid**):

■ Medical, Dental, Pharmacy, Outreach, Patient Services, PRC, Billing and Referrals

☐ BHS _____ (**must initialed to be valid**)

Unless otherwise revoked, this consent expires _____(insert applicable date).

If no date is indicated, this **consent will expire 12 months after the date of signing this form**.

Signed:_____ Date:_____

Printed Name:_____

Witness:_____ Date:_____

Printed Name:_____

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Feather River Tribal Health, Inc. **Health History Form**

Name: _____ Medical Record #: _____
Last First Middle

Date Completed: _____ Date of Birth: _____

If you are completing this form or another person, what is your relationship to that person? _____ _____
Name Relationship

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

HEALTH HISTORY

Yes	No	Don't Know	
❑	❑	❑	Are you in good health?
❑	❑	❑	Has there been any change in your general health within the past year?
❑	❑	❑	Are you now under the care of a physician? If so, what is/are the condition(s) being treated?

_____

_____

Date of last physical exam: _____

Physician(s) _____
Name Phone Address/City/State/Zip

Physician(s) _____
Name Phone Address/City/State/Zip

❑	❑	❑	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? _____

_____

❑	❑	❑	Are you taking, or have you taken, any diet drugs such as Pondimin (fendluramine), Redux (dexphenfluramine), or phen-fen?
❑	❑	❑	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? _____

In the past month? _____ If yes, _____# of drinks per day for _____# years

❑	❑	❑	Are you alcohol and/or drug dependent? If so, have you received treatment? (check one) ❑ Yes ❑No
❑	❑	❑	Do you use drugs or other substances for recreational purposes? If yes, please list _____

Frequency of use (daily, weekly, etc.): _____
Number of years of recreational drug use _____

❑	❑	❑	Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (check one) ❑ Very ❑Somewhat ❑Not Interested

Amount per day: _____ Number of years _____

❑	❑	❑	Do you wear glasses or contact lenses?
☐	☐	☐	Are you legally blind?

ALLERGIES: ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Seasonal/Hay fever	❑	❑	❑	Animal
❑	❑	❑	Latex	❑	❑	❑	Iodine
❑	❑	❑	Food (specify) _____	❑	❑	❑	Other (specify) _____

If yes, specify type of reaction:_____

BLOOD DISORDERS: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Abnormal bleeding	❑	❑	❑	Hemophilia
❑	❑	❑	Anemia	❑	❑	❑	Blood Transfusion If yes, date:_____

CARDIOVASCULAR DISEASE: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Angina	❑	❑	❑	Heart Attack If yes, date:_____
❑	❑	❑	Arteriosclerosis	❑	❑	❑	Heart Murmur
❑	❑	❑	Artificial Heart Valve	❑	❑	❑	High Blood Pressure
❑	❑	❑	Chest Pain	❑	❑	❑	Low Blood Pressure
❑	❑	❑	Congenital Heart Defect	❑	❑	❑	Mitral Valve Prolapse
❑	❑	❑	Coronary Insufficiency	❑	❑	❑	Pacemaker If yes, date:_____
☐	☐	☐	Coronary Occlusion	☐	☐	☐	Rheumatic Heart Disease
☐	☐	☐	Damaged Heart Valves				

DIABETES: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Type 1 Onset Date:_____	❑	❑	❑	Type 2 Onset Date:_____

DENTAL INFORMATION

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Do your gums bleed when you brush?	❑	❑	❑	Have you ever had orthodontic (braces) treatment?
❑	❑	❑	Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑	Do you have headaches, earaches or neck pains?
❑	❑	❑	Have you had any periodontal (gum) treatments?	❑	❑	❑	Do you wear removable dental appliances?
❑	❑	❑	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain:				

How would you describe your current dental problem? _____

Date of your last dental exam: _____ Date of last dental x-rays: _____

What was done at that time? _____

How do you feel about the appearance of your teeth? _____

I hereby give permission to the dentist to render routine dental services and/or oral surgery deemed necessary including topical and local anesthesia – **Initial** X_____

GASTROINTESTINAL DISORDERS: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Constipation	❑	❑	❑	Severe Weight Gain
❑	❑	❑	Eating Disorder Specify:_____	❑	❑	❑	Severe Weight Loss
❑	❑	❑	Malnutrition	❑	❑	❑	Sores or Ulcers in the Mouth
❑	❑	❑	Persistent Diarrhea	❑	❑	❑	Stomach Ulcers
❑	❑	❑	Reflux				

HEADACHES: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Chronic	❑	❑	❑	Severe
❑	❑	❑	Migraine				

IMMUNE SYSTEMS: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	AIDS or HIV	❑	❑	❑	Disease, drug or radiation – Induced Immunosuppression

KIDNEY DISORDERS: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Difficulty Urination	❑	❑	❑	Excessive Urination
❑	❑	❑	Kidney disorder	❑	❑	❑	History of Kidney Stones
			Specify:_____				Date:_____

NEUROLOGICAL: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Epilepsy	❑	❑	❑	Fainting Spells or Seizures
❑	❑	❑	Diagnosed Disorder	❑	❑	❑	Stroke
			If yes, list:_____				If yes, when:_____

ORTHOPEDIC: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Arthritis	❑	❑	❑	Osteoporosis
❑	❑	❑	Have you had a total joint replacement? If so, what joint, when & where?_____				
☐	☐	☐	Did you have any complications? If yes, what:_____				

RESPIRATORY: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Asthma	❑	❑	❑	Emphysema
❑	❑	❑	Bronchitis	❑	❑	❑	Have you had a positive TB skin test
❑	❑	❑	Do you have active Tuberculosis	❑	❑	❑	Night Sweats
❑	❑	❑	Do you have a persistent cough greater than 3 weeks duration	❑	❑	❑	Do you have a cough that produces blood

RHEUMATOLOGY: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Lupus	❑	❑	❑	Rheumatoid Arthritis
☐	☐	☐	Fibromyalgia	☐	☐	☐	Other _____

NAME_____ MR#_____ DOB_____

WOMEN ONLY

Yes	No	Don't Know		
❑	❑	❑	Are you pregnant?	Date of last menses (period) _____
❑	❑	❑	Are you nursing?	Date of last pap smear _____
❑	❑	❑	Are you taking birth control pills?	Date of last mammogram _____
☐	☐	☐	Pregnancy Number of:_____	Live Births Number of:_____

MISC: (PLEASE FILL OUT BOTH COLUMNS)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	Dry mouth	❑	❑	❑	Glaucoma
☐	☐	☐	Hepatitis, jaundice or liver disease	❑	❑	❑	Sinus Trouble
☐	☐	☐	Sleep Disorder	☐	☐	☐	Thyroid Trouble

❑	❑	❑	Do you have any other diseases, conditions or problems not listed above? Please explain:_____
☐	☐	☐	Do you have a diagnosis of Hep B or Hep C?
☐	☐	☐	Do you have chronic pain? If yes, where?_____ How treated?_____
☐	☐	☐	Do you have or have you had cancer, chemotherapy or radiation treatment? If yes, please indicate location of cancer and what treatment you received:_____
☐	☐	☐	Do you have recurrent infections? If yes, specify type of infection:_____
☐	☐	☐	Mental Health Disorders? If yes, specify:_____
☐	☐	☐	Sexually Transmitted Disease? If so, what and when?_____
☐	☐	☐	Persistent swollen glands in the neck

PAST SURGERIES (IF NONE WRITE NONE)

TYPE OF SURGERY/PROCEDURE	DATE PERFORMED	TYPE OF SURGERY/PROCEDURE	DATE PERFORMED
Have you had a Colonoscopy? ❑ Yes ❑ No			

FAMILY ROSTER *Please include yourself*

NAME	SEX	RELATIONSHIP TO PATIENT	DATE OF BIRTH	AGE
PATIENT -		**SELF**		

FAMILY HISTORY (BIOLOGICAL)

PARENT INFORMATION:
Are your parents alive? Mother ❑ Yes ❑ No Father ❑ Yes ❑ No
If no, at what age did they die? Mother_____ Father_____

If yes, what medical problems do/did they have? See list below.

MOTHER	FATHER
☐High Blood Pressure ☐Diabetes ☐ Heart Attack ☐Alcoholism ☐Ulcers ☐Gall Bladder Disease ☐Strokes ☐Cancer (type)_____	☐High Blood Pressure ☐Diabetes ☐ Heart Attack ☐Alcoholism ☐Ulcers ☐Gall Bladder Disease ☐Strokes ☐Cancer (type)_____
Other: ☐ **Unknown**	Other: ☐ **Unknown**

SISTER AND BROTHER INFO:
Do you have any brothers or sisters?
Sister(s) ❑ Yes ❑ No Brother(s) ❑ Yes ❑ No

How many? Sister(s)_____ Brother(s)_____

Are they alive?
Sister(s) ❑ Yes ❑ No Brother(s) ❑ Yes ❑ No

If no, at what age did they die?
Sister(s)_____ Brother(s)_____

Do they have any medical problems? ☐High Blood Pressure ☐Diabetes ☐ Heart Attack ☐Alcoholism ☐Ulcers ☐Gall Bladder Disease ☐Strokes ☐Cancer (type)_____

Other: _____
_____ ☐ **Unknown**

Do any of the following illnesses seem to occur among your relatives? **Please list relative**(s) (i.e. Aunt, Uncle, Grandparent, etc.): ☐ **Unknown**

High Blood Pressure _____	Diabetes _____	Heart Attack _____
Cancer (type) _____	Alcoholism _____	Ulcers _____
Gall Bladder Disease _____	Strokes _____	Other _____

SIGNATURES:

SIGNATURE / Patient **Date** Provider: Date

Parent/Guardian: **Date**
Relationship:

CURRENT MEDICATION (if none write none)	DOSE	FREQUENCY	PRESCRIBING PROVIDER OR IF OVER-THE-COUNTER

Have you used any controlled meds in the last 6 months (i.e. pain meds or psych meds)?
☐ **Yes** ☐ **No** If yes, please list below.

CURRENT MEDICATION (if none write none)	DOSE	FREQUENCY	PRESCRIBING PROVIDER

Are you allergic to any medications? ☐ **Yes** ☐ **No** If yes, list below.

NAME OF MEDICATION ALLERGIC TO	REACTION

☐ **For additional info see 2nd page**

SIGNATURE:_____ **DATE:**_____

RELEASE OF INFORMATION

❑ New Pt

FEATHER RIVER TRIBAL HEALTH, INC. (FRTH)
555 W. ONSTOTT RD ♦ YUBA CITY CA 95993-5654 ♦ (530) 751-8454 ♦ FAX (530) 751-8456

PATIENT INFORMATION: Tell us about yourself or the person this form is for.

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

NICKNAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE NUMBER: _____

WHO IS SHARING:

WHO IS **GIVING** YOUR INFORMATION?	WHO IS **GETTING** YOUR INFORMATION?
❑ **FEATHER RIVER TRIBAL HEALTH, INC. (FRTH)** 555 W. ONSTOTT RD YUBA CITY CA 95965-5654	❑ **FEATHER RIVER TRIBAL HEALTH, INC. (FRTH)** 555 W. ONSTOTT RD YUBA CITY CA 95965-5654
❑ **CLINICIAN OR MEDICAL CENTER**	❑ **PATIENT OR LEGAL REPRESENTATIVE**
	❑ **CLINICIAN OR MEDICAL CENTER**
IF **NOT** FRTH:	NAME: _____
NAME: _____	RELATIONSHIP TO PATIENT: _____
FULL MAILING ADDRESS:	FULL MAILING ADDRESS:
_____	_____
_____	_____
_____	_____
FAX NUMBER: _____	FAX NUMBER: _____
PHONE NUMBER: _____	PHONE NUMBER: _____

HOW DO YOU WANT YOUR INFO SHARED: ❑ PAPER ❑ FAX TO: _____

WHY DO YOU WANT YOUR INFORMATION SHARED? WHAT IS IT GOING TO BE USED FOR?

❑**PATIENT REQUEST** ❑**CLINICIAN REQUEST** ❑**OTHER:** _____

This form complies with requirements of 45CFR164.508(c) & CA Civil Code §56.11

Patient Name_____ DOB_____ MR#_____

RELEASE OF INFORMATION

❑ New Pt

WHAT TO SHARE: This is where you can tell us what information you'd like shared.

WHAT INFORMATION WOULD YOU LIKE SHARED?		
❑ PROGRESS NOTES	FROM _____	TO _____ *(DATES)
❑ LAB RESULTS	FROM _____	TO _____ *(DATES)
❑ X-RAY/IMAGING/DIAGNOSTIC REPORTS:	FROM _____	TO _____ *(DATES)
❑ OTHER: _____		

SIGN HERE: By signing you are saying that you agree to the statement in the box.

I understand that certain information cannot be released without specific approval. This is needed by State and Federal law. Requests for disclosures for these types of records must be separate from other requests. I approve the release of the following protected or sensitive information:

Please **INITIAL** the records that can be shared.

_____ HIV/AIDS RELATED RECORDS _____ BEHAVIORAL/MENTAL HEALTH INFORMATION

_____ ALCOHOL/DRUG TREATMENT RECORDS

RIGHT TO REVOKE: I know I have the right to cancel this approval at any time. I know if I cancel this approval, I have to do it in writing and give my written statement to FRTH's Health Information Department. I know if I cancel, it will not apply to information that has already been shared because of this approval. I know if I cancel, it will not apply to my insurance company when the law lets them challenge a claim under my policy.

REDISCLOSURE: I know it's up to me if I want to share my health information. I know I don't need to sign this form in order to be treated at FRTH. I understand that redisclosure is not permitted unless in accordance with State and Federal law.

I know I can look at or get copies of the information that's being shared. This right is given by CFR 164.524. I know if I give approval the information shared with FRTH may be shared again with another medical center. This may not be protected by federal confidentiality rules. I know if I have questions about sharing my health information, I can call FRTH Health Information at (530) 534-5394.

I know unless I have canceled at an earlier time, this approval to share medical information will end on _____ (specific date or event). If no date or event is listed then this approval will end in one (1) year from the date signed.

SIGN: _____ **DATE:** _____

LEGAL REPRESENTATIVE (Relationship to patient/why you have authority to sign): _____

WITNESS (if needed _____ **DATE:** _____

Patient Name _____ DOB _____ MR# _____