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:
Partnership Health Plan or Kaiser

This information will affect you as a new patient and an established patient. The following process must be followed to become a patient 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.

ESTABLISHED 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 your health plan and change the PCP to FRTH.
   Partnership Member Services: 800-863-4155
   Kaiser Member Services: 855-839-7613
   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.**

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 -- ❑Partnership Health Plan ❑Kaiser ❑CMSP
❑Private Ins ❑Dental Ins ❑Prescription ❑Other:________________

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

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

3/19/2024

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: ______________________________ Work/Day Phone: ______________________

Mailing Address: ______________________________ Cell Phone: ______________________

City/State/Zip: ______________________________ Email: ______________________

- 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.

NAME ______________________________ DOB ____________________ MR# ______________

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

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:__________________________________

Patient Name:__________________________________ DOB:_____________ MR#:_____________

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 Specify:______________________	❑	❑	❑	History of Kidney Stones Date:______________________

NEUROLOGICAL: (PLEASE FILL OUT BOTH COLUMNS)

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

OBGYN HISTORY

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

Yes	No	Don't Know	
❑	❑	❑	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

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		

NAME________ MR#________ DOB________

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 **Relationship** **Date**

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 OR IF OVER-THE-COUNTER

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)

2145 5TH AVE ♦ OROVILLE CA 95965-5870 ♦ (530) 534-5394 ♦ FAX (530) 534-0748

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)** 2145 5TH AVE ♦ OROVILLE CA 95965-5870 ❑ **CLINICIAN OR MEDICAL CENTER**	❑ **FEATHER RIVER TRIBAL HEALTH, INC. (FRTH)** 2145 5TH AVE ♦ OROVILLE CA 95965-5870 ❑ **PATIENT OR LEGAL REPRESENTATIVE** ❑ **CLINICIAN OR MEDICAL CENTER**
IF **NOT** FRTH: NAME: ____________________ FULL MAILING ADDRESS: ____________________ ____________________ ____________________ FAX NUMBER: ____________________ PHONE NUMBER: ____________________	NAME: ____________________ RELATIONSHIP TO PATIENT: ____________________ FULL MAILING ADDRESS: ____________________ ____________________ ____________________ FAX 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#______________