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Patient Registration

Patient Information			
Last Name:	First Name:		Middle Initial:
Social Security #:	Date of Birth:		Gender at Birth: ☐ Male ☐ Female
Mailing Address:			
City:	State:		Zip Code:
Physical Address *(if different from mailing)*:			
City:	State:		Zip Code:
Home Phone #: ( )	Alt Phone #: ( )		Cell Phone #: ( )
Email:			
Preferred Language:	Do you need an interpreter? ☐ Yes ☐ No		
Marital Status:	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic		Veteran: ☐ Yes ☐ No
Race: ***Must fill out Tribal Information if selecting American Indian or Alaska Native.***			
☐ American Indian or Alaska Native	☐ Asian	☐ Black/African American	
☐ Native Hawaiian/Other Pacific Islander	☐ White	☐ Other	

Tribal Information			
Tribal Affiliation:	Tribe Roll #:		CA Roll #:
Fathers Name:	Place of Birth:	Date of Birth:	Tribe:
Mothers Name:	Place of Birth:	Date of Birth:	Tribe:

All Persons Living in Household *(Use separate sheet in needed)*		
Name:	Date of Birth:	Relationship:
Name:	Date of Birth:	Relationship:
Name:	Date of Birth:	Relationship:
Name:	Date of Birth:	Relationship:

Employment Information			
Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Other:			
Name of Employer:	Occupation:		Work Phone #: ( )
Address:	City:	State:	Zip:

Emergency Contact		
Name:	Phone #:( )	Relationship:
Name:	Phone #:( )	Relationship:

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Insurance Information		
Guarantor ☐ Self/Patient		
Name:	Date of Birth:	Social Security #:
Address:		
City:	State:	Zip:
Patient Insurance: ☐ Medicare ☐ Medi-Cal ☐ Partnership ☐ Private Insurance ☐ Other:		
Primary Insurance		
Name of policy holder:	Relationship to patient:	
Date of Birth:	Social Security #:	
Insurance Carrier:	ID#:	
Policy/Group #:		
Secondary Insurance		
Name of policy holder:	Relationship to patient:	
Date of Birth:	Social Security #:	
Insurance Carrier:	ID#:	
Policy/Group #:		

Consent to Treat

I hereby consent to and authorize the performance of all treatments, surgeries and medical services considered necessary or recommended by my clinician(s) and staff of Redding Rancheria Tribal Health System (RRTHS) to me or to the above-named minor for whom I am the parent or legal guardian.

I hereby certify that, to the best of my knowledge, all statements contained herein are true. I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any cost incurred by RRTHS in the collection of amounts due including, but not limited to, reasonable attorney fees.

I hereby assign all medical and/or surgical benefits including major benefits to which I am entitled including Medicare, private insurance and other health plans to RRTHS. The assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I further authorize the release of all information necessary to secure payment.

I understand that my consent will be carried over to other RRTHS locations if I choose another clinician or service within the Redding Rancheria Tribal Health System.

Patient Name:	Date:
Signature:	Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative
If signing for the patient, please print your name:	

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Personal Medical History

Please indicate if you have been diagnosed and/or treated for any of the following.

- ☐ ADHD
- ☐ Alcohol Dependence
- ☐ Allergies, Seasonal
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blood clots
- ☐ Cancer Type: _____
- ☐ Congestive heart failure
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Crohn's disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Type: _____
- ☐ Diverticulitis
- ☐ Gallbladder stones
- ☐ GERD /Acid Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart attack
- ☐ Heart Disease Type: _____
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Insomnia
- ☐ Irritable bowel syndrome
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Lupus
- ☐ Macular Degeneration
- ☐ Migraines
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Pulmonary Embolism (PE)
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Seizures/epilepsy
- ☐ Sleep Apnea
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ Thyroid disease Type: _____
- ☐ Tinnitus
- ☐ Tuberculosis
- ☐ Ulcerative Colitis

Please list any other medical problems not listed above: _____

_____

_____

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Family Medical History

Please list any family medical history.

Mother
☐ Alive
☐ Passed, Age: _____

☐ Heart problems ☐ Stroke ☐ High blood pressure
☐ High Cholesterol ☐ Mental Illness ☐ Alcohol/drug abuse
☐ Cancer, type: _____ ☐ Diabetes, type: _____
☐ Genetic disorder, type: _____ ☐ Other: _____

Father
☐ Alive
☐ Passed, Age: _____

☐ Heart problems ☐ Stroke ☐ High blood pressure
☐ High Cholesterol ☐ Mental Illness ☐ Alcohol/drug abuse
☐ Cancer, type: _____ ☐ Diabetes, type: _____
☐ Genetic disorder, type: _____ ☐ Other: _____

Sister
Alive: _____
Passed, Age: _____

☐ Heart problems ☐ Stroke ☐ High blood pressure
☐ High Cholesterol ☐ Mental Illness ☐ Alcohol/drug abuse
☐ Cancer, type: _____ ☐ Diabetes, type: _____
☐ Genetic disorder, type: _____ ☐ Other: _____

Brother
Alive: _____
Passed, Age: _____

☐ Heart problems ☐ Stroke ☐ High blood pressure
☐ High Cholesterol ☐ Mental Illness ☐ Alcohol/drug abuse
☐ Cancer, type: _____ ☐ Diabetes, type: _____
☐ Genetic disorder, type: _____ ☐ Other: _____

Grandmother (maternal)
☐ Alive
☐ Passed, Age: _____

☐ Heart problems ☐ Stroke ☐ High blood pressure
☐ High Cholesterol ☐ Mental Illness ☐ Alcohol/drug abuse
☐ Cancer, type: _____ ☐ Diabetes, type: _____
☐ Genetic disorder, type: _____ ☐ Other: _____

Grandmother (paternal)
☐ Alive
☐ Passed, Age: _____

☐ Heart problems ☐ Stroke ☐ High blood pressure
☐ High Cholesterol ☐ Mental Illness ☐ Alcohol/drug abuse
☐ Cancer, type: _____ ☐ Diabetes, type: _____
☐ Genetic disorder, type: _____ ☐ Other: _____

Grandfather (maternal)
☐ Alive
☐ Passed, Age: _____

☐ Heart problems ☐ Stroke ☐ High blood pressure
☐ High Cholesterol ☐ Mental Illness ☐ Alcohol/drug abuse
☐ Cancer, type: _____ ☐ Diabetes, type: _____
☐ Genetic disorder, type: _____ ☐ Other: _____

Grandfather (paternal)
☐ Alive
☐ Passed, Age: _____

☐ Heart problems ☐ Stroke ☐ High blood pressure
☐ High Cholesterol ☐ Mental Illness ☐ Alcohol/drug abuse
☐ Cancer, type: _____ ☐ Diabetes, type: _____
☐ Genetic disorder, type: _____ ☐ Other: _____

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Surgical History		
Please list any surgeries you have had and the year they took place.		
Surgery	**Year**	**Reason for Surgery**

Medications		
Please list all medications you take, including over-the counter (OTC) medications and vitamins.		
Medication Name	**Dose**	**Frequency**

Allergies

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list medication and reaction: _____

_____

Do you have any food allergies? ☐ Yes ☐ No

If yes, please list food and reaction: _____

_____

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Reproductive Health History

Have you ever had a sexually transmitted disease (STD)? ☐ Yes ☐ No Type: _____
Are you taking hormone replacement therapy? ☐ Yes ☐ No
Method of Birth Control: _____
Do you have a menstrual cycle? ☐ Yes ☐ No
Age of first menstruation: _____ Date of last menstruation: _____ Age or year when cycle stopped: _____
Are you currently pregnant? ☐ Yes ☐ No
Have you ever been pregnant? ☐ Yes ☐ No
# of pregnancies: _____ # of live births: _____ # of miscarriages: _____ # of abortions: _____

Social History - Adult

Lifestyle
Activity level: ☐ Sedentary ☐ Moderate ☐ Vigorous
Type of exercise: _____ Exercise frequency: _____times/week _____hours/week

Tobacco Use
Do you use tobacco products? ☐ Yes ☐ No ☐ Formerly Age started: _____ Age Stopped: _____
Type of tobacco *(cigarette, chew, vape etc.)*: _____
Pack or Units per day: _____

Alcohol
Do you drink alcohol? ☐ Yes ☐ No ☐ Formerly Year Quit: _____
Type of alcohol: _____ Frequency: _____
Amount: _____ Last Drink: _____
How many times in the past year have you had 5 or more drinks in a day? _____

Caffeine
Do you drink/consume caffeine? ☐ Yes ☐ No
Type of Caffeine: _____ Caffeine per day: _____

Drug/Substance Abuse
Do you use recreational drugs, such as marijuana, cocaine and/or methamphetamine?
☐ Yes ☐ No ☐ Formerly Year Quit: _____
Type: _____ Frequency: _____ Route: _____
Sought treatment for drug abuse: ☐ Yes ☐ No

Social History - Pediatric

Patient resides with:
Primary: ☐ Mother ☐ Father ☐ Both Parents ☐ Other: _____
Secondary: ☐ Mother ☐ Father ☐ Both Parents ☐ Other: _____
Mother's Occupation: _____
Father's Occupation: _____
Parents Relationship: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Tobacco Exposure
Smokers at home? ☐ Yes ☐ No Smoke outside only? ☐ Yes ☐ No

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Pharmacy Information	
Preferred Pharmacy Name:	Secondary Pharmacy Name:
Address:	Address:
Phone: Fax:	Phone: Fax:

Advanced Directives
☐ None ☐ DNR ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy