PATIENT REGISTRATION INFORMATION

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State ____ Zip code ____

Home Phone _____ Cellphone _____ Work Phone _____

Gender _____ Social Security Number _____ Marital Status _____

Date of Birth _____ Email _____

**New patients only:* are you registering with GLTHHS for primary care? □ Yes □No

TRIBAL INFORMATION *(If affiliated please complete the section below.)*

Tribal Affiliation (Name of Tribe):_____

□ Citizen of a Federally Recognized Tribe □ Citizen of a State Recognized Tribe □ Citizen of a Canadian Nation
□ Descendant of a Federally Recognized Tribe □ Other _____

Are you a Veteran? □ Yes ■ No

Branch of Service _____ Last Entry Date _____

Separation Date _____ Claim Number _____

EMERGENCY CONTACTS

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

OTHER INFORMATION – Mark all that apply

□ GLT Citizen □ GLT Citizen Household □ Other Tribe □ Other Tribe Household □ GLT Staff □ GLT Staff Household
□ GLC Staff □ GLC Staff Household □ Medicaid Beneficiary □ Other _____

Ethnicity	Race
□ Non-Hispanic or Latino	□ American Indian/Alaskan Native
□ Hispanic or Latino	□ Caucasian
□ Decline to Answer	□ African American
□ Unknown	□ Native Hawaiian
	□ Other: _____

Do you have an Advanced Directive

□ Yes □ No

EMPLOYER INFORMATION

Patient's Employer (if applicable) _____ □ Full-time □ Part-time

Employer Address _____

Spouse's Employer (if applicable) _____□ Full-time □ Part-time

Employer Address_____

PRIMARY INSURANCE

Insurance Name: _____ Policy Number: _____

Policy holder name: _____ Policy Holder Date of Birth _____

Group Number: _____ Policy Holder Social Security Number _____

Effective Date _____

SECONDARY INSURANCE

Insurance Name: _____ Policy Number: _____

Policy holder name: _____ Policy Holder Date of Birth _____

Group Number: _____ Policy Holder Social Security Number _____

Effective Date _____

OTHER INSURANCE NOT LISTED ABOVE:

_____

_____

IF YOU HAVE MEDICARE – DO YOU HAVE MEDICARE PART D?

□ Yes, I do have Medicare Part D
□ No, I do not have Medicare Part D

Dentist: _____

Optometrist: _____

List any specialty physicians that currently provide you with medical care

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

PATIENT/GUARDIAN ACKNOWLEDGEMENTS

□ Yes, I would like a copy of my Patient Rights and Responsibilities
□ No, I do not want a copy of my Patient Rights and Responsibilities

Patient Initials _____
I authorize my insurance benefits to be paid directly to the Gun Lake Tribal Health Center, GLT HHS. I Realize that if I am not an IHS Beneficiary, I am responsible to pay non-covered services and/or any co-pay/deductibles.

Patient Initials _____
I acknowledge that I have been offered or received a copy of the Notice of Privacy Practices and have been provided the opportunity to review it.

Patient Initials_____
I acknowledge that my insurance will be billed by the lab or facility that performs tests ordered by my provider. Any balance remaining is my responsibility.

Patient Initials_____
By providing my wireless phone number to Gun Lake Tribe Health and Human Services, I agree and acknowledge that Gun Lake Tribal Health Center may send text messages to my wireless phone number for any purpose, including promotional purposes.

Patient Initials_____
I understand that to utilize the services of the Gun Lake Tribal Health Center, patients must meet one of the following qualifications:

- American Indian/Alaskan Natives (AI/AN) who are Citizens OR descendants of a Federally Recognized Tribe
- Household member of an American Indian/Alaskan Native (AI/AN) who is a Citizen OR descendant of a Federally Recognized Tribe
- Employee of Gun Lake Tribe, Gun Lake Casino or Gun Lake Investments.
- Household member of an employee of Gun Lake Tribe, Gun Lake Casino or Gun Lake Investments.
- Medicaid beneficiary

Not meeting at least one of these qualifications will result in termination of services.

I certify that the information I have provided to the Gun Lake Tribe Health & Human Services staff is complete and accurate. I understand that if any information should change, it is my responsibility to provide Gun Lake Tribe Health & Human Services with all updated information (insurance card, verification of vision, dental and health coverage, name change, address changes).

I understand that if Gun Lake Tribe Health & Human Services makes unnecessary or improper payments on my behalf based on the information that I provided, I may be liable for such payments, and I may be ineligible for Gun Lake Tribe health services in the future.

I assign to Gun Lake Tribe Health & Human Services any medical, dental and/or behavioral health benefits that I am entitled to under the terms of my health care coverage, in whole or in part, for the services paid for, or provided by, the Gun Lake Tribe Health & Human Services.

I authorize the release of any medical information necessary to process my submitted claim.

Patient Name _____

Signature of Patient/Guardian _____Date _____

Gun Lake Tribe Health and Human Services
Consent: General, Treatment and Release of Information

Patient Name: _____
Date of Birth: _____

I, the undersigned, agree:

- Gun Lake Tribe Health and Human Services registration is applicable for all programs and services within the Health and Human Services that I am eligible for, however additional forms and questionnaires may be required when programs and services are accessed.
- To examination and treatment by providers, residents, students, and other healthcare professionals at Gun Lake Tribe Health and Human Services.
- That Gun Lake Tribe Health and Human Services may offer services in-person or through telemedicine, videotaping, photographing and audio devices to treat/diagnose or to prescribe procedures to be performed for medical, scientific and/or personal safety.
- As discussed, and agreed, the provider may change my and/or my child's care to benefit my life or health.
- The provider may obtain specimens of my blood, urine, and other bodily fluids/tissues (hereinafter "specimens"). The provider may dispose of these specimens as it chooses.
- This consent applies to the services that Gun Lake Tribe Health and Human Services provides, which include, but are not limited to: examination and treatment at the Gun lake Tribe Health Center, treatment at other property owned by the Gun Lake Tribe and/or at my home when in-home services are needed, and transportation services to assist patients on getting to and from the Gun Lake Tribe Health Center and to outside medical appointments.
- To provide patients with the best care and attention, we will be using a service called Freed AI that records and transcribes conversations to assist with documentation. Your information is private and will be reviewed by your provider to ensure the content is accurate after each visit.

I, the undersigned, understand that:

- I will ask questions.
- I am aware the practice of medicine is not an exact science. No one has made promises or guarantees to me about the results of my treatment, care, or examination at Gun Lake Tribe Health and Human Services.
- Students and staff may see me and look at my medical record for teaching or research purposes.
- Some providers and staff are not employees of Gun Lake Tribe, however, all direct services received will be billed by Gun Lake Tribe Health and Human Services.
- Michigan law allows healthcare providers to test my blood for HIV (AIDS virus) or Hepatitis without my consent if someone who has helped in my care is exposed to my blood or body fluids.
- Gun Lake Tribe Health and Human Services will not tolerate discrimination against my provider, other healthcare professionals or staff because of race, color, gender, national origin, age, disability, sex or any other basis prohibited by federal, state or local law.
- This consent is valid for one (1) year from the date of my signature.

MY MEDICAL INFORMATION:

- Gun Lake Tribe Health and Human Services may release my medical information to:
    - Insurance companies, health plans and administrators for payment of services I or my child receive(s).
    - Government agencies like Medicare and Medicaid or as required by law.
    - My providers and others involved in my care now or in the future.
    - My employer, if the records are related to care or services paid for by my employer, or for other purposes that are allowed under law.
    - Any person or entity responsible for paying all or part of my bill.
- I agree that Gun Lake Tribe Health and Human Services can take my or my child's picture and save it to my electronic medical record. I understand that this will be used for identification purposes.
- I understand Gun Lake Tribe Health and Human Services will keep my or my child's medical information according to state law, federal law and policy. I also understand that my medical information may be stored electronically and may be sent to and received from other healthcare providers and/or payers electronically. This includes my diagnosis, treatments, and medicine or prescription information. This will also include any details about my mental health, infectious disease(s) (like HIV), and other problems like drug or alcohol use disorder.
- I authorize my protected health information (PHI) to be sent to my MyChart (patient portal) account. MyChart is a secure internet portal that allows me to see, receive, and manage information about my health.
- I understand my protected health information (PHI) may include very personal information (e.g., physical/mental illness, alcohol/drug abuse, psychotherapy notes, communication with my provider, sexually transmitted infections (STIs), HIV/AIDS, etc.). If I give someone access to my MyChart portal or request my PHI be shared with a third-party, that third-party will be able to see my PHI (which may include very personal information). By allowing others access to my PHI, I understand that I would be agreeing that they can see my very personal information including my HIV/AIDS status.
- In some cases, Gun Lake Tribe Health and Human Services is required by law to report medical information to an agency like the health department. This may include information about HIV, TB and other communicable diseases.
- If I am transferred to another facility, Gun Lake Tribe health and Human Service's providers/resident providers, and/or clinical staff may access my medical records to follow up on my care and/or use the information for medical research.

PRIVACY NOTICE

- I have rights and responsibilities when I or my child receive(s) services. I have had the opportunity to receive a copy of the Notice of Privacy Practices and have had an opportunity to ask questions about the information in the notice.

VALUABLES

- Gun Lake Tribe Health and Human Services would like its patients to leave valuables at home or with family members. I agree Gun Lake Tribe Health and Human Services is not responsible for safeguarding my property.

PATIENT RIGHTS AND GRIEVANCES

- I understand that I may submit a concern or complaint without fear of reprisal or retaliation. Efforts will be made to resolve my concern promptly or within an appropriate timeframe. If I have questions about my rights as a patient, I may ask questions. Any staff member can provide me with a concern/complaint form, or I can call and speak to management to have a form completed over the phone.

CONSENT TO CONTACT

- I have given residential and/or cellular telephone numbers and an email address to Gun Lake Tribe Health and Human Services. I consent to receive autodialed and/or pre-recorded telephone calls, text messages and/or emails from Gun Lake Tribe Health and Human Services. These communications may include billing. I am responsible for any communication charges from my phone provider(s). This authorization is voluntary. I can still be treated even if I do not give "consent to contact".
- Text messages from Gun Lake Tribe Health and Human Services might include the date and time of my appointment, my provider's name, the name, and address of the location where my appointment is scheduled, and what I need to know to prepare for my appointment, amounts owed, or limited health information.

ASSIGNMENT

- I assign Gun Lake Tribe Health and Human Services:
    - All benefits, claims, and any and all other rights, including the right to bill and talk to any third party for the purpose of seeking payment, regarding my Gun Lake Tribe Health and Human Services charges.
    - The right to file suit or intervene in any lawsuit or proceeding which involves my Gun Lake Tribe Health and Human Services charges.
    - The right to take any other action to seek payment of my Gun Lake Tribe Health and Human Services charges.
- This assignment includes, but is not limited to, the right to appeal the denial of payment of my Gun Lake Tribe Health and Human Services charges from any payer, including any employer-sponsored benefit plan, insurance policy or insurance coverage provided by law or contract.
- I also assign to Gun Lake Tribe Health and Human Services, and agree that I waive, any and all rights to settle, release or retain payment of my Gun Lake Tribe Health and Human Services charges, or take any other action which would in any way compromise payment or reimbursement of my Gun Lake Tribe Health and Human Services charges.
- I also appoint Gun Lake Tribe Health and Human Services as my authorized representative for the purpose of pursuing payment for my Gun Lake Tribe Health and Human Services charges. I authorize Gun Lake Tribe Health and Human Services to act on my behalf to pursue any benefit claim, and to appeal an adverse benefit determination. I agree to assist Gun Lake Tribe Health and

Human Services in the pursuit of all insurance benefits and agree to pay all co-insurance, co-payments and deductibles required by any insurance plan.

- I authorize and direct Gun Lake Tribe Health and Human Services to apply the proceeds of any recovery to my Gun Lake Tribe Health and Human Services charges.

A photocopy of this consent shall be considered as valid as the original

PATIENT SIGNATURE(S)

I have read this form and I understand it. By signing below, I understand that I am agreeing to terms of this Agreement.

Patient Signature: _____ Date: _____ Time: _____

Patient is under 18 years of age or otherwise unable to consent because:

_____

Parent/Legal Guardian signature: _____

Printed Name: _____ Date: _____ Time: _____

STAFF SIGNATURE(S)

Witness: _____ Date: _____ Time: _____

Second Witness Needed for Verbal Consent

Witness: _____ Date: _____ Time: _____

Gun Lake Tribe Health and Human Services
Authorization: People involved in Patient's Care

Patient Name:_____
Date of Birth: _____

I have the right to choose family members, friends, or others to be involved in talks about my health care. The people listed below may receive any **verbal information** needed to be involved in my care or to help me make decisions about my care. By signing this form, I give my permission for staff within Gun Lake Tribe Health and Human Services to discuss information about me with the people listed. The information discussed may include diagnosis, test results, medicine, treatment options, billing, insurance, and other information from previous services I have had, either in hospitals or other locations.

- I know that information may be discussed with family members or others without this form, if allowed by federal and state laws.
- I know that listing a person on this form does not allow them to get or copy my medical records.
- People listed on this form are not allowed to give consent for services for me.
- For a minor, parents are assumed to be designated except for those services which the minor has given consent under Michigan Law.

LIST PEOPLE THAT MAY PICK UP PRESCRIPTIONS/MEDICINES AND RECEIVE VERBAL INFORMATION ABOUT YOUR CARE

☐ I DO NOT WISH TO NAME ANYONE

NAME	RELATIONSHIP	CONACT PHONE NUMBER(S)	ALLOWED TO RECEIVE VERBAL INFORMATION ABOUT YOUR CARE (Y/N)

The following information has special protection under Michigan law and will be made available to the people listed above ONLY IF I give my approval by checking the box(es) below.

- ☐ HIV/AIDS, Tuberculosis, Hepatitis, Venereal Diseases, sexually transmitted infections
- ☐ Substance abuse services
- ☐ Mental health services

I can update this form at any time by telling a Gun Lake Tribe Health and Human Services staff member AND by filling out a new form. I can take away my permission to share my information at any time by putting that request in writing and giving that request to a Gun Lake Tribe Health and Human Services staff member.

PATIENT SIGNATURE(S)
I have read this form and I understand it. All my questions have been answered.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

Patient Health History Form

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

Pronouns: ☐ **he/him** ☐ **she/her** ☐ **they/them**

Past Medical History *(Check all that apply)*

☐ Anemia
☐ Alcoholism
☐ Anxiety
☐ Arrhythmia
☐ Arthritis
☐ Asthma
☐ Bipolar disorder
☐ Blood Clots
☐ Bleeding disorder
☐ Cancer:
_____
☐ Chronic Lung Disease
☐ Chronic Infections
☐ Depression

☐ Diabetes
☐ Eating Disorder
☐ Glaucoma
☐ Headaches
☐ Hearing Impairment
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Problems
☐ Osteoporosis
☐ Pancreatitis
☐ Skin Problems

☐ Seizures
☐ Stroke
☐ Sleep Apnea
☐ Stomach/Bowel Problems
☐ Serious Accident/Injury
☐ Thyroid Disease
☐ Urinary Problems
☐ Vision Impairment
☐ Other:
_____
_____
_____

Past Surgical History *(Check and date)*

☐ Tonsillectomy: Date_____
☐ Cardiac Catherization: Date_____
☐ Coronary Bypass: Date_____
☐ Pacemaker: Date_____
☐ Gallbladder: Date_____
☐ Colonoscopy: Date_____
☐ C-section: Date_____
☐ Hysterectomy: Date_____
☐ Appendectomy: Date_____
☐ Other:
_____
_____
_____
_____

Family History

RELATIONSHIP	STATUS Use "A" for alive Use "D" for deceased	CANCER	DIABETES	HEART FAILURE	HYPERTENSION	ASTHMA	HIGH CHOLESTEROL	ARTHRITIS-RHEUMATOID	ARTHRISTIS-OSTEO	STROKE	THRYROID DISEASE	SEIZURES	MIGRAINES	RASHES/ SKIN PROBLEMS
Mother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Father		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Grandfather		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maternal Grandmother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Grandfather		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Paternal Grandmother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sister		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Brother		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Current Medications

_____ _____ _____

_____ _____ _____

ALLERGIES: _____

Sexual History

Sex assigned at birth: ☐ Female ☐ Male

Gender Identity: ☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Intersex ☐ I prefer not to say

Are you sexually active? ☐ Yes ☐ No

Are your partners ☐ Male ☐ Female ☐ Both ☐ Other

Females Only

Age of 1st period? _____ First Day of Last Menstrual cycle _____ I no longer have periods_____

Date of last PAP _____ Have you ever had an abnormal PAP smear? _____

Number of Pregnancies? _____ Live births_____

Are you currently using contraception? ☐ Yes ☐No If yes, what type are you using?

☐ Birth Control Pills/Patch ☐ Tubal Ligation (tubes tied) ☐ Diaphragm (Cup) ☐ abstinence ☐ Condoms

☐ Hysterectomy ☐ Partner with vasectomy ☐ IUD -year placed_____ ☐Implant Year placed_____

☐ Natural Planning ☐ Depo provera injection ☐ Other_____

Social History

Relationship status: ☐ married ☐ divorced ☐ widowed ☐ single ☐ other ☐ I prefer not to answer

Living situation: ☐ I live alone ☐ I live with others ☐ I prefer not to answer

Employment: ☐ currently employed ☐currently unemployed

Employer: _____

Hobbies:_____

Exercise: ☐ Never ☐Rarely ☐ 1-2 times weekly ☐ 3-4 times weekly ☐ 5-6 times weekly ☐ daily

Foods I choose to eat: ☐< 1 fruit/veggie daily ☐1-2 fruits/veggies daily ☐3-4 fruits and veggies daily ☐> 5 fruits and veggies daily

Caffeine: ☐None _____Number of Cups/Day

Tobacco Use: ☐ Non-Tobacco User ☐ Current Smoker, Amount/Day_____ # of Years: ____ ☐ Previous Smoker, Year Quit_____ ☐ Smoker in Home ☐ Ceremonial Use Only

Alcohol Use: ☐ Do not drink Number of Drink/Day_____ Number of Drink/Week_____

Other Drug Use: ☐ None ☐ History of use but none currently

☐Current User ☐ Marijuana ☐ Heroin ☐ Methamphetamine ☐Cocaine ☐ Other: _____

Health Screening:

Last Mammogram: _____ N/A ☐ Last Colonoscopy: _____ N/A ☐

Last bone density: _____ N/A ☐ Last blood work: _____ N/A ☐

Last Physical Exam _____ N/A☐

I would like to update my immunizations if I am due for any: ☐ Yes ☐ No

Patient Name: _____

Signature of Patient or Patient Representative: _____Date: _____