Health and Human Services
2880 Mission Drive, Shelbyville, MI 49344 | {p} 269.397.1760 | gunlaketribe-nsn.gov

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 _______________