SANTA FE INDIAN SCHOOL

Department of Student Wellness

Indian Health Services--Santa Fe Service Unit

*** TEAR THIS COVER PAGE OFF AND KEEP FOR YOUR RECORDS****

This packet is for the Indian Health Services-Santa Fe Service Unit (PHS). SFIS has a collaborative agreement with IHS to provide comprehensive primary care, dental, mental health, optometry services and pharmacy to our Santa Fe Indian School students (when signed parental consent is on file). They require these forms be updated annually.

Services include:

- ✓ Urgent care (Note: for emergency medical care IHS will call 911 and have student transported to Christus St. Vincent's Medical Center)
- ✓ Primary care (requires scheduled appointment)
- ✓ Athletic physicals (requires scheduled appointment)
- ✓ Dental care (requires scheduled appointment)
- ✓ Pharmacy

To schedule appointments or to inquire about your student's healthcare from IHS-SFSU please call: 505-988-9821

SFIS Health Center employees (School Nurse's office) do not have access to nor are responsible for IHS medical records, IHS appointment scheduling system, or transportation to/from appointments scheduled by parents.

***** If you decide to opt out of completing these forms your student will NOT be able to be seen for any primary care, urgent care, dental services, immunization, athletic physicals, etc. at IHS-SFSU.***

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Santa Fe Indian Hospital
1700 Cerrillos Road
Santa Fe. New Mexico 87501

Dear Parents and Legal Guardians of Santa Fe Indian School Students:

The Santa Fe Indian Health Service Dental Staff would like to provide routine dental care including x-rays, dental exam, sealant, cleaning, filling, and fluoride application for every Santa Fe Indian School student this year. In order to provide these routine services, we will need your written consent. **If you would like our staff to schedule a dental exam for your child at the Santa Fe Indian Hospital Dental Clinic for routine dental care**, please sign where indicated below and complete the attached Medical History Form.

With signed consent, these routine services may be provided without you having to be present. ***Please note: if more specialized services need to be done, such as a tooth pulled (extraction) or a root canal, the parent or legal guardian will need to be present for those procedures.***

Student Name: _____ Grade: _____ DOB: _____ Chart #: _____

For ease of scheduling, please check one for your student:
☐ Day Student ☐ Dorm Student

☐ Yes, I do give permission for my child to receive:

- X-rays and dental exam
- Sealants & Fluoride Varnish
- Cleaning
- Fillings
- Athletic Sportsguards

☐ Yes, I give permission for my child, but ONLY for:

- Sealants & Fluoride Varnish

☐ No, I do not wish for my child to receive any dental services at the Santa Fe Service Unit

_____ _____ _____
Parent/ Legal Guardian Signature Date Telephone #

Revised Feb 2020

Santa Fe Indian Hospital Dental Patient Agreement

Dear Patients:

In order to provide the very best dental services to the greatest number, patients are scheduled for appointments. Please carefully read the following:

Clinic hours are 8 AM to 5:00 PM: Appointments are scheduled Monday through Friday with the first appointment scheduled at 8 AM and the last appointment scheduled at 4PM. All routine care is provided after you have had your dental exam. **You should arrive 15-20 minutes** before your scheduled appointment to complete **patient registration**, unless your appointment is at **8AM or 1PM** (Please arrive **5 minutes** for these times). Please note, the number of appointments may be limited if staff shortages occur.

Cancelled Appointments: Please notify us 24-hours in advance if you are unable to keep your appointment. This enables us to better serve the community and to schedule other patients. Remember, the sooner you call the sooner we will reschedule your appointment.

Missing/Broken Appointments: If you are **10 minutes** late for your appointment it is considered a **broken appointment** and you will not be seen at your scheduled time; walk-in patients will be treated in your place. If you feel you need to be seen you're encouraged to stay and be seen as a walk-in patient. If you have **3 consecutive broken appointments**, we cannot reschedule or make an appointment for the next 6 months.

No Specialty Dental Care: We are **not** able to provide specialty dental services. Specialty Dental Care includes root canals, crowns and bridges, dentures, partials and certain surgical procedures. We apologize for any inconvenience this may create.

Emergency or Toothache Treatment: Patients with tooth pain can walk in for treatment Mon- Fri from **8-11AM (except for Wednesday mornings)** and must sign in by **1 PM in the afternoon**. Please note patients with appointments will be seen first. This means you may have to wait hours before you are called into the treatment area. **Patients who arrive at the clinic after 1 PM may be advised of treatment options and encouraged to return the next day for treatment depending on staff availability.** Patients need to be present in the Dental waiting area.

Treatment of Minors: A minor is defined as anyone under the age of 18 years. A parent/legal guardian or family member with written consent must accompany all minors for treatment. However, a parent or legal guardian must accompany the minor for the initial exam appointment and be present for any irreversible procedures such as removing a tooth.

Children in the Treatment Area: For safety and infection control reasons, if your child cannot sit still and needs your attention and there is no one to watch your child, then your appointment will be rescheduled.

Children in the Waiting Room: Please do not leave your child/children unattended. If you are unable to secure childcare, we will reschedule your appointment.

Intoxicated Patients: For your safety and the safety of the staff, intoxicated patients will be rescheduled.

I have read and am in agreement with this policy. The Dentist and/or Dental Assistant have answered my questions to my satisfaction.

Patient/Guardian Signature	**Date**	**Dentist/Dental Asst. Signature**	**Date**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
DENTAL PATIENT MEDICAL HISTORY

Please complete these two pages so that we can better provide care for your oral health problems. If you are unsure of how to answer any of the questions, please ask the dental staff for help.

Your name: _____ (Last Name / First Name / MI) Date of Birth: ____ - ____ - ____ (Month / Day / Year)

What is the purpose of your visit to our office today? _____

_____

Do you have a toothache now? ☐ Yes ☐ No If yes, for how long? _____

On a scale of 1-10, with 10 being the most painful, what is your pain level today (write a number): ☐

Do you have or have you had any of the following conditions?

	Yes	No	If Yes, Please Describe (include dates, if known)
Circulatory System			
Do you have any congenital heart disease, defect, or heart murmur?	☐	☐	
Do you have, or have you ever had, heart disease or congestive heart failure?	☐	☐	
Have you ever had a heart attack?	☐	☐	
Do you have high blood pressure (hypertension)?	☐	☐	
Have you ever had bacterial endocarditis?	☐	☐	
Do you, or have you ever had, chest pain or angina?	☐	☐	
Have you had anemia or abnormal bruising or bleeding?	☐	☐	
Are you taking any blood thinners (Plavix, baby aspirin, etc.)? If so, which one?	☐	☐	
Do you have a pacemaker, defibrillator, or other artificial heart device?	☐	☐	
Immune System			
Have you ever had an organ transplant?	☐	☐	
Have you had your spleen removed?	☐	☐	
Are you on steroids (prednisone) or biological drugs (Humira) now?	☐	☐	
Do you have HIV or AIDS, or do you believe you have been exposed?	☐	☐	
Do you have lupus, rheumatoid arthritis, or any immune condition?	☐	☐	
Have you ever had cancer or tumors?	☐	☐	
Have you ever received, or are you now receiving, chemotherapy or radiation?	☐	☐	
Excretory System			
Have you ever had any kidney problems, including dialysis?	☐	☐	
Have you ever had hepatitis? If so, what type and is it currently active?	☐	☐	
Do you have any type of liver disease?	☐	☐	
Endocrine System			
Do you have diabetes, and if so, what type?	☐	☐	
Have you had thyroid problems of any kind? If so, was it high or low thyroid?	☐	☐	
Nervous System			
Have you ever had a stroke?	☐	☐	
Have you ever had epilepsy, seizures, or a nervous system disorder?	☐	☐	
Over the past 2 weeks, have you had little interest or pleasure in doing things?	☐	☐	
Over the past 2 weeks, have you felt down, depressed, or hopeless?	☐	☐	
Musculo-Skeletal System			
Do you have osteoporosis or taken medicine for osteoporosis?	☐	☐	
Have you ever had a joint replaced (hip, knee, ankle, shoulder)?	☐	☐	
Respiratory System			
Do you have asthma or any lung disease?	☐	☐	
Have you ever had tuberculosis?	☐	☐	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
DENTAL PATIENT MEDICAL HISTORY

	Yes	No	If Yes, Please Describe (include dates, if known)
Reproductive System			
Have you ever had a sexually transmitted disease (STD)?			
WOMEN ONLY: Are you currently pregnant? If yes, how many weeks?			
WOMEN ONLY: Are you currently nursing?			
WOMEN ONLY: Are you taking birth control?			
General Questions			
Do you have any physical or mental disability that requires special consideration?			
Have you ever experienced vertigo, dizziness, or fainting?			
Do you have any allergies to latex, iodine, red dye, food, medications? If so, list:			
Do you smoke or chew tobacco?			If yes, do you want to quit? _____
Have you ever had any type of operation or surgery? If so, please list.			
Have you ever been hospitalized? If yes, describe when and why.			
Are you allergic to any medications, or do any make you sick? If so, please list.			
Do you have any disease, condition, or problem not listed? If yes, please list.			

When was your last medical appointment? (please list date): _____ - _____ - _____
Month Day Year

What was the purpose of that appointment? _____

Who is your primary care physician/provider? _____

Please list **all medications** you currently take (including over-the-counter drugs and herbal supplements):

Medication Name	What is it for?	How often do you take it?	What dosage (mg, etc)?

Please carefully read and sign the statement below.

The answers I have given above are true to the best of my knowledge. I am indicating my consent for routine diagnostic tests and procedures such as x-rays, cleaning, blood pressure, and fluoride by signing below on behalf of myself or the above named minor in my guardianship.

Patient Signature: _____ Date/Time: _____

Provider Signature: _____ Date/Time: _____

**********PROVIDER NOTES**********

Provider Name: _____ Patient Health Record Number: _____

Notes: _____

Acknowledgement of Receipt of IHS Notice of Privacy Practices

I hereby acknowledge of receipt of the Indian Health Services (IHS) Notice of Privacy Practices at:

Santa Fe Indian Hospital
1700 Cerrillos Road
Santa Fe, NM 87505

_____	_____
Signature of Patient	Date
_____	_____
Parent Signature if under 18 years	Date
_____	_____
Patient Registration Signature	Date

For Patients Unable to Acknowledge Receipt:

I hereby certify that the patient is unable to acknowledge receipt of the IHS Notice of Practices Because:

_____

_____	_____
Patient Registration Signature	Date

SANTA FE SERVICE UNIT-PHS INDIAN HOSPITAL
1700 Cerrillos Rd, SANTA FE, NEW MEXICO 87505
(505) 988-9821

SERVICE AGREEMENT

1. **AUTHORIZATION FOR HOSPITAL CARE AND EMERGENCY ROOM TREATMENT:**
The Undersigned voluntarily agrees to treatment and services that his/her physician deems necessary.

2. **RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW:**
Santa Fe I.H.S. and Tribal Sites may disclose all or any reasonable part of the patient's record excluding information pertaining to medical history, mental or physical condition, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing all or part of the hospital's charges to include but not limited to any person, insurance companies, employer, pre-admission review, utilization review, evaluation, financial audit for any other purposes reasonably related to these activities. The undersigned understands that this authorization will remain in effect for a long term period of inpatient and outpatient services, unless revoked in writing prior to that date.

3. **ASSIGNMENT OF INSURANCE BENEFITS – PRIVATE HEALTH INSURANCE:**
I hereby authorize payment directly to the Santa Fe Service Unit for hospital benefits otherwise payable to me but not to exceed the hospitals regular charges for this period of services or hospitalization. Authorization is not limited to private health insurance but may include other sources such as Medicare/Medicaid, Liability claims and/or reimbursable insurance for my services I receive.

4. **MEDICAID:**
State regulations require you to present a current identification card every time you are admitted or receive service. Every patient is required to submit an application for Medicaid if referred by a Physician, Benefits Coordinator, Contract Health Service or other provider. Lack of compliance with the Medicaid application process may result in a denial for Contract Health Service until an application is completed.

5. **MEDICARE:**
This program covers hospitalization if it is determined that it is medically necessary for the patient to be admitted to receive health care. By signing this agreement I have given this facility a "Statement of Permit for Payment of Medicare Benefits to this Provider" it is my understanding that the Professional Review Organization and its agents may receive information needed to determine benefits payable.

6. **NON-BENEFICIARY FINANCIAL AGREEMENT for Emergency Services ONLY:**
The undersigned agrees individually as follows: That in consideration for the services rendered to the patient, he/she obligates himself/herself and the patient to pay the account of the hospital in accordance with the regular rates and terms of this hospital. Any cost denied by an insurance agent or other responsible party, including co-payments and deductibles will be the responsibility of the parent/patient or guardian. Medicaid: If you do not identify yourself as a Medicaid recipient, you will be responsible for this bill. You will also be responsible for the Emergency Room charges for all Non-Emergency visits. Services not paid or covered under the Medicaid program will be billed to the patient or Guardian. Medicare: You are expected to pay the Medicare deductible and co-insurance. If for some reason your hospitalization does not meet the requirement of your insurance agency you will be responsible for the entire bill. **If you Do Not have on File a Certificate of Indian Blood (CIB) nor present proof of Eligibility from a Federally Recognized Tribe (IHS Circular Part 2 Ch 1 2-1.1) within 30-days; you will be billed for all services rendered and thereafter, You will Not be allowed to receive further services until proof is Provided. _____ inital**

7. **PATIENT RIGHTS AND RESPONSIBILITIES:**
Patient Rights and Responsibilities have been explained to me and I understand my rights as a patient or guardian. Advance Directives has been briefly explained to me and if I should have any questions, I must speak with my Physician or other designated Advance Directives liaison. Privacy Act: I have been given notice and read the Privacy Act Notice and the laws, which govern my rights as a patient. Additional, I was given information of where I may obtain additional Information on Advance Directives. I acknowledge I DO [ ] DO NOT [ ] Have an advance Directive

8. **PURCHASED/REFERRED CARE (PRC)**
I fully understand my responsibility under the CHS regulations. I understand the CHS is not an insurance program or an entitlement program. I must notify CHS within 72 hours or obtain Prior Approval for CHS services. I understand that I must comply with the regulations outlined under the alternate resource notice. **____ initial**

9. **AGREEMENT:**
By signing this form I understand the contents of the service agreement and have received a copy. Interpreting of this agreement was explained to me in English and/or in my native language.

_____ _____
Patient's/Guardian/Guarantor Signature **Date** **Interviewer's Signature** **Date**

Patient Name: _____ **Chart No:** _____

01/2012

SANTA FE SERVICE UNIT

1700 CERRILLOS ROAD, SANTA FE, NM 87505

Patient Registration Form

Patient Information				**Is this a Job Related Injury? Y N**		
Last	First			MI	Date of Birth	Marital Status M D S
City/State of Birth	Sex	SSN		Current Community/How Long?		
Mailing Address		City		State		Zip
Physical Address		City		State		Zip
Cell Phone ( )	Home Phone ( )	Work Phone ( )		Have you ever been seen at any of our Other clinics: (circle all that apply) 1. Santa Clara Clinic 2. San Felipe Clinic 3. Cochiti Clinic 4. Santo Domingo Clinic		
Religious Preference	Tribe of Membership	Tribe Quantum				
Indian Blood Quantum	Other Tribes	CIB/Enrollment				
Place of Employment Name & Address		City/State		Phone # ( )		
Fathers Name, (Last, First, Middle)		Mothers Maiden Name (Last, First, Middle)				
Fathers Place of Birth (City & State)		Mothers Place of Birth (City & State)				
Father's Place of Employment (required for patients under 18 years)		Mother's Place of Employment (required for patients under 18 years)				
Emergency Contact Name		Phone # ( )		Relationship		
Emergency Contact Address		City		State		Zip
Next of Kin Name		Phone # ( )		Relationship		
Next of Kin Address		City		State		Zip

Insurance Information

Do You have any of the following? Medicare Medicaid Private Insurance Workman's Comp
(Circle all that apply)

Tricare Tricare For Life Dental Insurance

Please Provide a Copy of Insurance Card(s)

Are you active Duty or a Dependent of Active Duty? Yes No	If Yes Circle the appropriate designation	If Active Duty or have Tricare, what Tricare Region are you Enrolled in?
	Commissioned Corps USPHS Military DoD Other Active Duty	West South North

Are you a Veteran of the Armed Forces? Yes No	Do you receive or Qualify for Health Care Benefits at the VA? Yes No
If yes what Branch?	

If you have none of the Third Party resources listed above, have you ever been screened by a Benefits Coordinator to see If you qualify for any third party assistance? Yes No

TURN PAGE OVER-Continued

If you have any of the listed resources on the previous page, please provide the following Insurance Information

Medical Insurance		**Other Insurance**	
Insurance Name		Insurance Name	
Policy Holder Name		Policy Holder Name	
Policy Holder Date of Birth		Policy Holder Date of Birth	
Group Name		Group Name	
Policy #	Group #	Policy #	Group #
Expiration Date		Expiration Date	

Dental Insurance	**Pharmacy Insurance/ Medicare Part D Coverage**
Insurance Name	Insurance Name
Policy Holder Name	Policy Holder Name
Policy ID # or SS #	Policy ID # or SS #
Group #	Group #
Expiration Date	Expiration Date

Previous Health Care		
Please list the clinic(s), Hospital or IHS Facility you receive your health care at before coming to Santa Fe Indian Hospital: (including out of state)		
Name of Facility	City/State	Phone # ( )
Name of Facility	City/State	Phone # ( )
Name of Facility	City/State	Phone # ( )

New Chart Number_____ Registration Clerk Name_____