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_____

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

Consent for Treatment

I authorize the Santa Fe Service Unit Dental Team to perform the clinical procedures necessary to treat pain, decay and / or infection present in my mouth. My dental condition has been explained to me and have discussed alternative treatment options (if available) with the Dental Team. I understand that a printed copy of my treatment plan is available upon request.

I understand that there are risks associated with any dental treatment(s). Also, I understand that it is common for my Dental Team to numb areas of my mouth so that treatments can be completed with minimal discomfort; and, that the risks from numbing may include discomfort, rapid pulse (fluttery heart beat), swelling, bleeding, bruising and /or lip biting.

My dentist has given me the opportunity to discuss these risks and all of my questions have been answered to my satisfaction. I understand that any treatment provided by my dental team is intended to help me and my teeth but that a perfect result cannot be guaranteed. I am aware of my right to decline treatment of any kind and I am aware of the possible consequences of non-treatment. My dentist will help me determine the best filling material (silver amalgam or white resin) to be used for my cavity, depending on my individual risk factors to ensure that my filling will last a long time.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the treatment plan.

In the event of a medical emergency, I give my consent for these individuals to administer emergency medications and to perform any necessary life-saving procedures.

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

_____ _____

Patient/ Guardian Signature Date Patient/ Guardian Signature Date

Patient Name:
Chart #:
DOB:

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

Patient Name: _____ Date of Birth: ____ - ____ - ____
Last Name First Name MI Month Day Year

Please complete this form so that we can better provide care for your oral health needs.

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 0-10, with 10 being the most painful, what is your pain level today? _____

How confident are you filling out medical forms by yourself? (Check one)

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Extremely

If you are unsure of how to answer any of the questions, please ask the dental staff for help.

Please respond by circling the number that mostly closely answers	**Not At All**	**Several Days**	**Over Half the Days**	**Nearly Every Day**
Over the past 2 weeks, have you had little interest or pleasure in doing things?	0	1	2	3
Over the past 2 weeks, have you felt down, depressed, or hopeless?	0	1	2	3
Personal Safety				
Do you feel safe at home? ☐ Yes ☐ No Would you like to discuss your safety with a provider? ☐ Yes ☐ No				

Have you ever had any of the following conditions?	**Yes**	**No**	**Dates if known and short description**
Circulatory System			
Congenital heart disease, defect, or heart murmur?			
Heart disease or congestive heart failure?			
Heart attack?			
High blood pressure (hypertension)?			
Bacterial endocarditis?			
Chest pain or angina?			
Anemia or abnormal bruising or bleeding?			
Do you have a pacemaker, defibrillator, or other artificial heart device?			
Do you take blood thinners (e.g. Plavix, baby aspirin, Coumadin, warfarin)?			
Immune System			
Organ transplant or on organ transplant list?			
Spleen removed?			
Addison's or Cushing's disease, chronic steroid use (e.g. prednisone, etc.)			
HIV or AIDS, or do you believe you have been exposed?			
Lupus, rheumatoid arthritis, or any autoimmune condition?			
Irritable bowel syndrome, Crohn's disease, stomach ulcers, or gastric bypass?			
Cancer, tumors, chemotherapy, or radiation?			
Do you take medications that suppress your immune system (e.g. Remicade)?			
Excretory System			
Kidney problems, including dialysis?			
Hepatitis? If so, what type and is it currently active?			
Do you have any type of liver condition?			
Endocrine System			
Diabetes? If yes, what type?			
Thyroid problems of any kind? If yes, was it high or low thyroid?			
Do you take a thyroid medication (e.g. Synthroid, levothyroxine)?			
Nervous System			
Stroke?			
Epilepsy, seizures, multiple sclerosis or a nervous system disorder?			
Musculoskeletal System			
Osteoporosis or taken medicine for osteoporosis? Please list.			
Joint replacement (hip, knee, ankle, shoulder)?			
Osteoarthritis (i.e. degenerative arthritis)?			

→ *Continued on next page*

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

Patient Name: _____ Date of Birth: ____ - ____ - ____
Last Name First Name MI Month Day Year

	Yes	No	Dates if known and short description
Respiratory System			
Asthma or chronic lung disease (e.g. emphysema, COPD, chronic bronchitis)?			
Tuberculosis, histoplasmosis, cystic fibrosis, blastomycosis?			
Reproductive System			
Sexually transmitted disease (STD)?			
WOMEN ONLY – Are you currently:			
Pregnant or potentially pregnant? ☐ Yes ☐ No If yes, how many weeks?			
Breastfeeding? ☐ Yes ☐ No Using birth control (other than physical barrier devices)? ☐ Yes ☐ No			
Substance Use			
(check all that apply) Do you: ☐ smoke ☐ chew tobacco ☐ vape ☐ use e-cigarettes ☐ traditional tobacco			
Aside from traditional tobacco use, would you like help quitting? ☐ Yes ☐ No			
To identify possible contraindications, do you use/consume any of the following ? ☐ alcohol ☐ marijuana ☐ other recreational drug			
In recovery or treatment for substance use?			
Have you been on a Pain Agreement or utilized Methadone or Suboxone?			
General Questions	**Yes**	**No**	**Dates if known and short description**
Do you have any physical or mental disability requiring special consideration?			
Experienced vertigo, dizziness, or fainting?			
Have you ever had any type of operation or surgery? If yes, please list.			
Have you ever been hospitalized? If yes, describe when and why.			
Any disease or condition not listed? If yes, please list.			
(check all that apply)			
Do you have **allergies or reactions** to any of the following: ☐ penicillin ☐ sulfa ☐ local anesthetics ☐ metal ☐ latex			
Do you have seasonal, food, or insect allergies, or any other sensitivities? ☐ yes ☐ no (If yes please list below)			
Please list other allergies/sensitivities: _____			

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

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

Date of last medical appointment? _____ - ____ - ____ Purpose of that appointment? _____
Month Day Year

Who is your primary care physician/provider? _____

Please carefully read the following statement and sign 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, local anesthesia, fillings, crowns, and fluoride by signing below on behalf of myself or the above named minor in my guardianship.

Patient/Guardian Signature: _____ Date/Time: _____

Provider Signature: _____ Date/Time: _____

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

Provider Name: _____ Patient Health Record Number: _____

Notes: _____

_____

Santa Fe Indian Hospital Dental Patient Agreement

Dear Patients: In order to provide the very best dental services, 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 3:30PM. All routine care is provided after you have had your dental exam. **You should arrive 15 minutes** before your scheduled appointment to complete **patient registration** and necessary paperwork.

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. If you are sick or having any cold or flu symptoms, please call to reschedule your appointment.

Missing/Broken Appointments: If you are more than **10 minutes** late for your appointment it is considered a broken appointment and you may be reschedule if other patients are being treated in your place. 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.

Urgent Care/Emergency Treatment: Patients with urgent dental needs or tooth pain can call the dental clinic to schedule an appointment for urgent/ emergent dental treatment during clinic hours, Mon- Fri. Please note: Patients can no longer "walk-in" to the dental clinic without an appointment.

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 & 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