

Absentee Shawnee Tribal Health Programs Intake Form

NOTE: Please print clearly and fill in every blank or check the correct response. Use n/a if not applicable.

General Information

Date: _____

Name: _____ Gender: _____ DOB: _____

CDIB/Roll #: _____ Tribe: _____ SSN: _____

Primary Address: _____

City, State, Zip: _____ Phone # _____

Alternate Address: _____

City, State, Zip: _____ Phone # _____

Relationships

	Name	Relationship	Phone #
Mother:	_____	_____	_____
Father:	_____	_____	_____
Emergency contact:	_____	_____	_____
Responsible party:	_____	_____	_____
Employer:	_____	_____	_____

Insurance

Primary Insurance

Company Name: _____ Ins. Co. Phone # _____

Type: PPO HMO Coverage: Single Family Source: Employer Group Non-Group

Group # _____ Policy # _____ BIN # _____ PCN # _____ Person code: _____

Dates covered: _____ to _____ Service(s) covered: Medical Dental Vision Prescription

Policy-holder's name: _____ Primary Care Physician: _____ PCP # _____

Policy-holder's address, city, state, zip: _____

Gender: _____ DOB: _____ SSN: _____ Phone # _____

Secondary Insurance or Medicaid Information

Company Name: _____ Ins. Co. Phone # _____

Type: PPO HMO Coverage: Single Family Source: Employer Group Non-Group

Group # _____ Policy # _____ BIN # _____ PCN # _____ Person code: _____

Dates covered: _____ to _____ Service(s) covered: Medical Dental Vision Prescription

Policy-holder's name: _____ Primary Care Physician: _____ PCP # _____

Policy-holder's address, city, state, zip: _____

Gender: _____ DOB: _____ SSN: _____ Phone # _____

Other Insurance

Do you have veteran's insurance?: Yes No Start date: _____

Do you have Medicare?: A B D Medicare # _____

Do you have Medicaid?: Yes No Medicaid # _____

Office use only

Data entry by _____

Medical History

Are you currently experiencing pain?: Yes No

If yes, describe location, duration and intensity: _____

Do you currently smoke?: Yes No If yes, how much?: _____

Have you ever smoked?: Yes No If yes, for how long?: _____

What medications are you currently taking?: _____

What medications are you allergic to?: _____

Are you presently under a doctor's care?: Yes No If yes, why?: _____

Have you been hospitalized?: Yes No If yes, why?: _____

Have you ever received radiation treatment?: Yes No If yes, why?: _____

Are your immunizations current?: Yes No Not sure

Have you ever had any amputations?: Yes No

Are you currently on dialysis?: Yes No

Have you ever had laser eye surgery?: Yes No

Are you currently pregnant?: Yes No Not sure

How often do you use alcohol?: Never Rarely Moderately Frequently Daily

When was your last mammogram?: _____

If you have Diabetes, what was the date you were first diagnosed?: _____

Have you had a pap smear in the last year? Yes No If so, when?: _____

Please check any of the following conditions that either you or a close relative have had:

	Self	Relative		Self	Relative
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Bone/joint problems	<input type="checkbox"/>	<input type="checkbox"/>	Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Current infection	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stomach disorder	<input type="checkbox"/>	<input type="checkbox"/>
Eye/ear/nose problems	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Emotional disorders	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>
Heart disorder/disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis/jaundice	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Weight change	<input type="checkbox"/>	<input type="checkbox"/>

Consent for Treatment, Release of Information, and Assignment of Benefits

I consent to medical treatment and diagnostic testing deemed necessary by my provider for myself or the minor child listed below to whom I am parent or legal guardian. Proof of guardianship is attached.

Additionally, I consent to the use, review, and release of information relevant to my health status and my medical records to health care providers, insurance carriers, Social Security Administration and its intermediaries and carriers, state and federal agencies if required by law, and the Absentee Shawnee Tribe of Oklahoma for the following uses:

- 1. Quality assessment, peer review, and utilization review conducted by the Tribe
- 2. Clinical studies, research, and education conducted by the Tribe, its employees, and/or agents
- 3. Determination of liability for payment and/or reimbursement of claims resulting from services and/or treatment
- 4. Claim processing and the issuance of benefits (COB's) to medical providers
- 5. Determining eligibility for Medicare and Medicaid programs

I understand that the information I have authorized for release may indicate the presence of communicable and/or venereal diseases including hepatitis, sexually transmitted diseases, the Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS).

I authorize payment of insurance benefits to be paid directly to the Absentee Shawnee Tribal Clinic for services provided by Clinic providers, and authorize the release of information necessary to secure payment of insurance benefits. I agree that a photocopy of this consent shall have the same validity as the original.

Signature of Patient/Legal Guardian	Date	Signature of Witness	Date
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Acknowledgment of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signature of Patient/Legal Guardian	Date	Relationship (if not signed by Patient)
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I wish to place the following restrictions on disclosure of my health information:

Office use only -- if patient/representative refuses to sign acknowledgment, please document date/time notice was presented to patient and sign: _____

Document presented by (name and title)	Date and time
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Certification Statement

I freely certify and attest that the information in this Intake Form is correct to the best of my knowledge and belief. I understand that falsification of information may subject me to legal liability. I understand that my information will not be used or released by the Absentee Shawnee Tribe of Oklahoma in any form other than general statistical data.

Signature of Patient/Legal Guardian	Date
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