Welcome Letter - Medical/Dental

Reviewed: 04/2023 - Revised: 05/2024

Welcome to NATIVE HEALTH! We are honored that you have chosen NATIVE HEALTH to care for you and your family. We are committed to providing quality health care that serves you and your family, at NATIVE HEALTH's Patient Centered Medical and Dental Home.

Our mission is to provide accessible holistic patient centered care, to empower our community to achieve the highest quality health and well-being. In the tradition of our Native American heritage, we demonstrate hospitality and respect toward every person we encounter. At this time, there are in-person medical, behavioral health, and emergency dental appointments. Telephonic and virtual medical, behavioral health, and emergency dental appointments are also available (Monday-Friday, 8:00 a.m.-7:00 p.m.)

We understand that times have changed, and therefore the way we normally welcome you as a new patient is different.

For that reason, if you have any questions at all while reviewing and signing these forms, please feel free to reach out to ANY of the following individuals, regardless of which site you would like to utilize, while completing paperwork:

Brooke Clark, Medical - **(602) 279-5262, ext. 14017 | bclark@nachci.com**

Jose Arturo Lopez-Leon, Medical - **(602) 279-5262, ext. 34014 | jleon@nachci.com**

Gina Begay, Dental Customer Service - **(602) 279-5262, ext. 14010 | vbegay@nachci.com**

To make sure your New Patient Paperwork process goes smoothly, please take a moment to review this checklist before completing your paperwork online or returning it in person.

- Did you PRINT, INITIAL, and/or SIGN your name on all of the paperwork in this packet where you see the word "client", "patient", "guardian", and/or "legal representative' or complete the entire online packet?
- Please ask us for any COPIES of any of the forms you would like a copy of.
- You will be asked to provide the front desk with a copy of your ID, Tribal ID, court and/or legal documentation or ` guardianship paperwork, and your AHCCCS or insurance card (as applicable).

Again, welcome to NATIVE HEALTH. We are looking forward to working with you!

Sincerely,

NATIVE HEALTH

Patient Rights and Responsibilities

Notice of Privacy Practices

Your Patient Centered Medical and Dental Home Guide

Notice of Nondiscrimination

New Patient Registration Form - ABBREVIATED

Reviewed: 07/2021 / Revised: 05/2024

First Name:______________________ Last Name:______________________

Date of Birth:__________ Sex at birth: ☐Female ☐Male

What pronoun do you prefer to be addressed by: ☐She ☐He ☐They ☐Zie/Hir ☐Other:__________

If patient is a minor (under age 18), please complete below. (Guardians required to provide supporting document).

Parent/Guardian Last Name:______________________ Relationship to minor: ☐Mother ☐Father ☐Guardian

Address:______________________________ State:_____ Zip:________

Primary Phone Number:________________ Secondary Phone Number:________________

Email:______________________ Is residence: ☐temporary ☐permanent

Contact Preference: ☐Primary Phone ☐Secondary Phone ☐Email ☐Text

Preferred NATIVE HEALTH Provider:______________________

NATIVE HEALTH cannot guarantee the security of messages sent by email or text and by initialing here you consent to using email or text even with the risk that the messages may be intercepted and read by a third party. _______ (initial) You have the right to at any time request that NATIVE HEALTH communicate with you using alternative means or to alternative locations. Please ask for assistance if you are interested in changing your contact preferences.

Emergency Contact Name:________________ Relationship:________ Phone:__________

Can we call Emergency Contact for Appointment Reminders? ☐Yes ☐No

Demographic Information

Your honest answer to the following questions will assist NATIVE HEALTH in providing the best services to you as an individual, and to qualify for resources that help support the services we provide.

Ethnicity: ☐ Not Hispanic Latino ☐ Mexican/Mexican American/Chicano ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic ☐ Chose not to Disclose Ethnicity ☐ Decline to Specify Hispanic or Latin Origin

Race: ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian Alaska Native ☐ White ☐ Choose not to disclose race ☐ Other

Primary Language: ☐ English ☐ Spanish ☐ Other

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

Sexual Orientation: ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Straight/Heterosexual ☐ Don't want to disclose ☐ Don't know/Questioning ☐Other

Gender Identity: ☐ Male ☐ Female ☐ Transgender Man ☐ Transgender Female ☐ Other ☐ Choose Not to Disclose

Approximate Total Annual Household Income: ☐$0-$20,000 ☐$21,000-$30,000 ☐$31,000-$40,000 ☐$41,000-$50,000 ______________________☐$51,000-$80,000 ☐$81,000+

Number of People in your Household: (includes spouse and children, under 18 years old)
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐Other:____

New Patient Registration Form - ABBREVIATED

Tribal Information
If you are affiliated with a Native American Tribe, please complete this section. If you are not affiliated with a Native American Tribe skip this section and complete the next section.

Tribe of Membership:____

Tribe of Quantum:____________ Indian Blood Quantum:____________ Tribal Enrollments #:____________

Other Tribe:____

Insurance Information:

Do you have health insurance?**:** ☐Yes ☐No (skip to next section)

Primary Plan Carrier Name:________________________________ Primary Plan Carrier Phone Number:______________

Policy #:____________________________________ Group #:____

Health Insurance Effective Date:______________

Policy Holder: ☐Self ☐Other:_________________________

Do you have other insurance? ☐Yes ☐No (skip to next section)

Secondary Plan Carrier Name:________________________________ Secondary Plan Carrier Phone #:______________

Secondary Policy #:____________________________ Secondary Group #:________________________________

Service Discount Program
You may be eligible for a discount on the cost of your health care depending on your family size and gross annual income. Please speak to a Family Health Advocate (FHA) to apply for the Discount Program at NATIVE HEALTH. If you qualify, you can receive a reduced out-of-pocket cost.

Would you like to apply for the Discount Program? ☐Yes (please see an FHA) ☐No

Would you like to apply for the AHCCCS (AZ State Medicaid)? ☐Yes (please see an FHA) ☐No

New Patient Registration Form - ABBREVIATED

Reviewed: 07/2021 / Revised: 05/2024

Consent for Treatment and Agreements of Financial Responsibility

By signing below, I am authorizing and consenting to all care and treatment provided by NATIVE HEALTH/NHW Community Health Center and its affiliated health care providers, which may include students, residents, volunteers and other trainees. Through this consent, I am authorizing all care, including medical care, dental care, radiologic and diagnostic examinations, laboratory procedures and tests, and general medical and behavioral health care services requested or ordered by my health care provider. I understand that I may refuse services from a student, resident or trainee.

I authorize NATIVE HEALTH/NHW Community Health Center to submit claims for services rendered to my health insurer(s), including, Medicare, Medicaid, or other insurance company, and assign benefits payable for my services to NATIVE HEALTH/NHW Community Health Center. I understand that unless I am covered by an insurer, including federal and state health care programs, I am responsible for and agree to pay all amounts not paid for by my insurer(s), including applicable coinsurance and/or deductible amounts. If my insurer pays me directly for services rendered by NATIVE HEALTH/NHW Community Health Center, I will provide NATIVE HEALTH/NHW Community Health Center with copies of the insurer's "Explanation of Benefits" and forward all payments received from my insurer to NATIVE HEALTH/NHW Community Health Center immediately upon receipt.

By signing below, I agree that all of the information that I have provided above and in the Medical/Dental History forms are true and accurate to the best of my knowledge, that I have read and understand this form and that all of my questions have been asked and answered. I have been provided a QR code to the NATIVE HEALTH "Patient Rights and Responsibilities" and acknowledge I have the responsibility to be involved in my care. I am signing this consent form willingly and voluntarily.

Patient/Legal Representative signature:______________________________ Date:__________

First Name:______________________________ Last Name:______________________________

For MINORS:

Patient Parent/Guardian signature:______________________________ Date:__________

Patient Parent/Guardian Name (print) First name:____________________ Last name:____________________

For Guardians and Legal Representatives, please provide supporting documents that proves you are the patient's guardian/Legal Representative.

Medical and Dental History - ABBREVIATED

Patient Name:________________________ Date of Birth:__________ Sex: ☐M ☐F

Medical History

Name of Physician:________________________ Phone:__________

Physician's Address:________________________ When was your last physical?__________

Are your immunizations up to date? ☐Yes ☐No

Are you now under the care of a physician? ☐Yes ☐No

Are you presently taking any medications/drugs/pills that include over-the-counter medications and dietary supplements?
☐Yes ☐No

If yes, please list any medications and supplements you are taking:

Medication name	How much	How often

Have you ever received a colorectal cancer screening (colonoscopy or stool test)? ☐Yes ☐No

If yes, approximate date and type:________________________

Are you sensitive or allergic to latex? (i.e. experienced itching, rash or wheezing after using latex gloves or handling a balloon)
☐Yes ☐No

Are you allergic or have an adverse reaction to:

☐None ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Aspirin ☐Other Antibiotic ☐Other

If yes, please describe:________________________

Do you have ANY allergies? This includes medication, food, environmental, etc. ☐Yes ☐No ☐Unsure

Please list any known allergies and their reaction:

Medication, food, environmental etc:	Reaction-symptoms (rash, swelling, etc):	Severity (mild, moderate or severe)

Have you had any unusual or unexplained reactions during a surgical procedure? ☐Yes ☐No

Have you had any other serious illness, hospitalization or accident ☐Yes ☐No

Medical and Dental History - ABBREVIATED

Do you have, or have had any of the following: (Yes or No)

Condition		Condition		Condition	
Abnormal Blood Pressure	☐Yes ☐No	Fainting Spells	☐Yes ☐No	Prolonged Bleeding	☐Yes ☐No
Alcohol Addiction	☐Yes ☐No	Glaucoma	☐Yes ☐No	Prosthetic Implants	☐Yes ☐No
Anemia	☐Yes ☐No	Hearing Impaired	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Anorexia	☐Yes ☐No	Heart Disease/Surgery	☐Yes ☐No	Radiation Therapy	☐Yes ☐No
Arthritis/Reumatism	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Recreational Drugs	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Heart Pace Maker	☐Yes ☐No	Removal of Spleen	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Hemophilia	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Asthma	☐Yes ☐No	Hepatitis	☐Yes ☐No	Rheumatic Heart Disease	☐Yes ☐No
Bulimia	☐Yes ☐No	HIV Positive/AIDS	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Cancer	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Learning Disability	☐Yes ☐No	Stroke	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Liver Disease	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Congenital Heart Disease	☐Yes ☐No	Lung Disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tumors	☐Yes ☐No
Diabetes	☐Yes ☐No	Neurological Disorders	☐Yes ☐No	Ulcers	☐Yes ☐No
Emphysema	☐Yes ☐No	Organ Transplant	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Epilepsy	☐Yes ☐No	Osteoporosis	☐Yes ☐No		

Have you used tobacco? ☐Yes ☐No **Have you used tobacco products in the last 30 days?** ☐Yes ☐No

Do you currently use the following tobacco products? ☐Cigarette ☐E-Cigarette ☐Cigar ☐Pipe ☐None

Do you currently use the following non-smoking tobacco products? ☐Chew ☐Smokeless ☐Snuff ☐None

Do you drink alcoholic beverages? ☐Yes ☐No

If yes, types of Alcohol: ☐Beer ☐Beer and liquor ☐Beer and wine, gin, hard liquor, rum, scotch, vodka, whiskey, wine

Frequency: ☐Daily ☐Weekly ☐Monthly ☐Yearly ☐Occasionally ☐Rarely ☐Socially

Amount: ☐1 beer ☐1 drink ☐1 fifth ☐1 glass ☐1 pint ☐2 beers… etc to > 5 glasses ☐6 pk of beer, 8 oz.

Last drink: ☐Last month ☐Last night ☐Last week ☐One year ago ☐Today ☐Two weeks ago ☐Yesterday

How many times in the past year have you had 4 or more drinks in a day?____

Do you drink/consume caffeine? ☐Yes ☐No

Types of caffeine: ☐Chocolate ☐Coffee ☐Energy drinks ☐Soda ☐Tablets ☐Tea

Caffeine per day: ☐1 cup ☐2 cups ☐6 cups ☐8 oz ☐32 oz

Do you use marijuana? ☐Yes ☐No **Do you use other substances?** ☐Yes ☐No

DENTAL HISTORY

Do you have any dental concerns? ☐Yes ☐No *(NATIVE HEALTH STAFF: If yes, contact Dental Department)*

Request for Communication of Medical Information by Confidential or Alternative Means or Locations

Reviewed: 08/2021 / Revised: 05/2024

NATIVE HEALTH is committed to maintaining the confidentiality of your health information and to allowing you to choose how we communicate with you.

If you do not want NATIVE HEALTH to communicate with you using the contact information you provided in your registration form, you may designate a preferred method or location for NATIVE HEALTH to communicate with you by completing this form.

Alternate Address for sending mail:

Street Address:______________________________

City:______________ State:______________ Zip Code______

Alternate phone number(s):______________

Alternate phone number(s):______________

☐ May leave a voicemail message ☐ May send a text message

E-mail address(es): ______________________

: ______________________

By signing below, you are consenting to NATIVE HEALTH communicating with you using the address(es) and phone number(s) identified above and not using the information you provided during your registration. You also understand that NATIVE HEALTH cannot guarantee the security of messages sent through e-mail and that there is a risk that e-mail that is not encrypted may be intercepted. You understand that you may change your contact preferences by notifying NATIVE HEALTH in writing.

Patient/Legal Representative signature:______________________ Date:______

Patient Name *(print)*:______________________

Authority to act if signed by legal representative: ☐ Yes ☐ No

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY AND FRIENDS

If you want NATIVE HEALTH to be able to discuss your health information with any family members or close friends, please identify those individuals by name and their relationship to you:

Name *(print)*:______________________ Relationship to Patient:____________

Name *(print)*:______________________ Relationship to Patient:____________

Name *(print)*:______________________ Relationship to Patient:____________

Name *(print)*:______________________ Relationship to Patient:____________

Request for Communication of Medical Information by Confidential or Alternative Means or Locations

Reviewed: 08/2021 / Revised: 05/2024

Patient/Legal Representative

Name *(print)*:____

E-mail address(es): ____

Authority to act if signed by legal representative? ☐Yes ☐No

CONSENT TO COMMUNICATE BY EMAIL OR TEXT MESSAGING

NATIVE HEALTH, its patients and their representatives often find it convenient to communicate by e-mail or text messaging. Such communications may include, but are not limited to, appointment reminders, providing test results, information about available services, customer survey requests, marketing of goods and services, and other important notices related to NATIVE HEALTH.

Because email and text messaging are not secure methods of communication, there is some level of risk that the email or text message could be read by a third party and NATIVE HEALTH cannot assure the confidentiality of information that it sends to you, or that you send to NATIVE HEALTH over email or through text messaging.

By signing below, you are authorizing and agreeing: to NATIVE HEALTH sending you email or text messages at the following address(es)/number(s) or at such other addresses or numbers you have provided to NATIVE HEALTH or may provide in the future; and that such calls or messages may be sent using an automatic telephone dialing system or prerecorded or artificial voice:

______ Initial here if you are willing to receive NATIVE HEALTH promotional or marketing messages at the phone number(s) and/or email address(es) above. You are not required to agree to accept such calls or messages from NATIVE HEALTH as a condition of receiving services.

Note that you should never communicate by email or text message with Native Health about any matter that is time sensitive or if you are experiencing an emergency. Please call NATIVE HEALTH directly, OR IN AN EMERGENCY, CALL 9-1-1.

I have read and understand this Consent to Communicate by Email or Text Messaging and consent to NATIVE HEALTH communicating with me as described above.

Patient/Legal Representative signature:____ Date:______________

Treatment/Payment Agreement Medical

I request NATIVE HEALTH provide me and/or my family with medical, dental or behavioral health care. I acknowledge my responsibilities to pay for the care according to the fees established. Furthermore, I authorize assignment of insurance/benefits for medical, dental or behavioral health services to be paid to NATIVE HEALTH. By signing below I also acknowledge I have received a copy and explanation of the Health Insurance Portability and Accountability Act Privacy Rule.

Further, I understand that I am responsible for payment of any services I request for myself/family that are not covered by my insurance/benefits package or do not have health insurance. NATIVE HEALTH reserves the right to collect any unpaid amounts.

BY SIGNING THIS AGREEMENT, I ATTEST THAT ALL INFORMATION PROVIDED DURING REGISTRATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Patient/Legal Representative signature:____ Date:____________

First Name (print):____________________________ Last Name (print):____________________________

FOR MINORS (under age 18)

Patient Name:____

Parent/Guardian Signature:____ Date:____________

Parent/Guardian First Name:______________________ Parent/Guardian Last Name:______________________

NATIVE HEALTH Front Desk Representative signature:____