Laguna Community Health Center
New Patient Registration Form
(Please Complete One Form For Every New Patient. Present This Form Along With Required Documents To Establish Your Patient Record)

Patient Name: ________________________________ Date of Birth: ________________________________

Social Security Number: _____________ City of Birth: ____________________ State of Birth: __________

Sex: Male___ Female___ Marital Status: _______________ Religious Preference: ___________________

Physical Address (*No P.O. Box*): ____

Mailing Address: ____________________ City: _______________ State: ______ Zip Code: ___________

Home Phone: ________________ Mobile Phone: _______________ Message Phone: _______________

Date Moved To This Address: ________________ Community/Village of Residence: _________________

Tribal Affiliation: ____ Tribal Blood Quantum: _____________

Tribal Enrollment Number: ___________________ Other Tribal Affiliation: ________________________

Other Tribal Blood Quantum: _________________

Mother's Name: _________________________ Mother's Maiden Name: __________________________

Mother's City of Birth: ____________________ Mother's State of Birth: ___________________________

Father's Name: __________________________ Father's City of Birth: ____________________________

Father's State of Birth: ____________________

- ***If registering a minor patient, please list parent's employer information below***

Employer/Mother's Employer: ____

Employer Address: ___________________________________ City: _________________ State: _______

Zip Code: ___________________ Phone Number: ____

Spouse Employer/Father's Employer: ____

Employer Address: ___________________________________ City: _________________ State: _______

Zip Code: ___________________ Phone Number: ____

Emergency Contact: ________________________________ Relationship to Patient: ___________________

Emergency Contact Mailing Address: _______________________ City: ______________________________

State: _______ Zip Code: _______________ Phone Number: ______________________________________

Next of Kin: _______________________________________ Relationship to Patient: ___________________

Next of Kin Address: _____________________________________ City: _______________________________

State: _______ Zip Code: _______________ Phone Number: ______________________________________

Medicare: Yes ____ No ____ If yes, What is your Medicare MBI #: _________________________________

Medicaid: Yes ____ No ____ If yes, Are You Enrolled In A Centennial Care Plan? Yes ____ No____

Blue Centennial Care: _____ Presbyterian Centennial Care: ____ Western Sky: ____

Please Provide Your ID #: _________________________________

Private Insurance: Yes ____ No ____ If yes, Name of Insurance Plan: ________________________________

Policy Holder: _______________________________________ Date of Birth: ___________________________

Insurance ID #: _____________________ Group ID: ______________________ Start Date: ______________

Are You A Veteran? Yes ____ No____ If Yes, What Branch? _______________________________________

Do You Have A Valid VA Card? Yes ____ No ____ Are You Service Connected? Yes ____ No ____

Do You Have Access To The Internet? Yes ____ No ____ If Yes, Where? _____________________________

What Is Your Email Address? ____

What Is Your Communication Preference? Phone ____ Mail ____

I understand an Electronic Health Record will be created at the Laguna Community Health Center. I certify the above information is true to the best of my knowledge and no information is deliberately falsified.

___________________________________ ___________________________

Signature of Patient/Legal Guardian Today's Date

LCHC Staff Use Only:

Health Record Number: _______________

Updated 04.08.2021