CHEROKEE NATION HEALTH SERVICES
REGISTRATION AND CONSENT FOR COMMUNITY BASED MEDICAL SERVICES
ADULT AND EMANCIPATED MINOR
(PLEASE FILL OUT COMPLETELY)

Name_____ Date of Birth__/__/____Social Security #_____

Sex: M F Current Mailing Address_____State_____ZipCode_____

Home Telephone #: ( ) _____ Alternate Telephone Phone _____

Mother's Full Maiden Name _____Tribe_____ Degree_____

Marital Status (circle one): Single Married Divorced Widowed

Father's Name_____ Tribe_____ Degree_____

Medicaid/Soonercare #_____ Medicare # _____

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PRIVATE INSURANCE and POLICYHOLDER information (if Applicable):

Policy ID#_____ Policyholder name: _____

Address: _____State _____Zip_____ Policyholder Date of birth: _____/_____/_____

Group #_____ Effective/Beginning Date of Policy: _____

Name of Insurance Carrier: _____

Insurance Address: _____ Insurance Phone #_____

Employer Name and Address: _____

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Consent and Acknowledgement

I understand that the information given by me/or collected is necessary for the Cherokee Nation Health Services (CN Health) to provide for my health and wellbeing. I understand CN Health will seek payment from any medical program that I might be eligible to participate in or from any liable third party and I assign to CN Health all benefits for services rendered by CN Health. I understand that CN Health may verify the information necessary to process the claim.

I have been offered a copy of the CN Health Notice of Information Practices.

I give permission for CN Health to provide the following services to me: medical exams, laboratory studies, routine exams, fillings, preventive fluorides and emergency dental care, behavioral health services including evaluation and treatment, emergency health services including evaluation and treatment, and public health services.

The information given by me is true and correct to the best of my knowledge and belief.

_____ _____

Signature Date

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