Cherokee Nation Health Services
Registration and Consent for Community Based Medical Services - MINOR

Please fill out completely

Name: Last ________________ First ________________ M.I. _______ Other Names Used ________________

Sex: M F Date of Birth __________ Tribe of Membership ________________ Tribal Number ____________

Social Security Number ______________ Mother's Maiden Name ____________ Father's Name ______________

Home Phone: ____________________________ Alternate Phone: ______________________________

Currently Mailing Address: ____

City: ____________________ State: __________ Zip: ____________

If child is not Indian, is child living in home with step parent, foster parent, adoptive parent, or guardian who is Indian? Y N

Parent/Guardian Phone # During School Hours ______________ Medicaid/SoonerCare # ______________

Medical Insurance Company ________________________________ Policy # ______________________

Effective/Beginning Date of Policy: ____

Address of Insurance Company ____

Name of Person Carrying Insurance Policy ________________ Relationship to Child ________________

If your child has a chart at an Indian Hospital or Indian Clinic, please give the name of the hospital(s) or clinic(s), alternate names for your child and the chart number if available

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Consent for Non-Invasive Preventive Services

I am the parent or legal guardian of ______________________. I give my permission for my child to have non-invasive procedures such as vision screenings, dental screenings, hearing screenings and head lice checks given by Cherokee Nation Health Services.

Parent/Guardian Signature: ____ Date ______________________

Consent for Immunizations/Finger stick

I am the parent or legal guardian of ______________________. I give my permission for my child to have the following immunizations and/or finger stick given by Cherokee Nation Health Services.

Hepatitis A_____ Hepatitis B_____ HiB _____

DTaP (Diphtheria, Tetanus & Whooping Cough) _____ Varicella (Chickenpox) _____ IPV (Polio) _____

MMR (Measles, Mumps, Rubella) _____ Pneumococcal_____ Tdap/Td_____

Meningitis_____ Rotavirus_____ HPV_____

Influenza_____ Finger stick_____ Other_____

Parent/Guardian Signature: ________________________________ Date ________________ Time __________

Witness Signature: ____________________________________ Date ________________ Time __________

Internal Use Only Community ______________

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

Name: Last ________________First ___________________M.I. ________ Other Names Used_______________

Sex: M F Date of Birth ___________ Marital Status (Circle One) Single Married Divorced Widowed

Tribe of Membership _______________ Tribal Number _____________ Social Security Number ___________

Mother's Maiden Name ___________________________ Father's Name _____________________________

Home Phone: _________________________ Alternate Phone: ______________________________________

Current Mailing Address: ____

City: ____ State: ____________ Zip Code: _________________

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.

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Patient Signature **Date** **Time**

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Witness Signature **Date** **Time**

Internal use only Community______________________________ CNH-PHN-07-DC (2/2017)