Shane Warner
Chairman

Darren B. Parry
Vice Chairman

NORTHWESTERN BAND OF THE SHOSHONE NATION
707 North Main Street
Brigham City, UT 84302 – 435-734-2286

PERSONAL INFORMATION

Name
Last:_____ First:_____ M:_____

Other Names Used:_____ SSN:_____

Date of Birth:_____ Male_____ Female_____

Place of Birth City:_____ State:_____

Current Address	Employment Information
Street:	
City/State:	Address:
Zip Code:	City/State:
Home Phone:	Telephone#:
Message/ Cell:	Work Status: (circle one below)
Email:	FULL PART TEMPORARY

Tribal Information

Tribe Enrolled In:_____

Enrollment#:_____ Blood Quantum:_____

Other Tribe: _____ Blood Quantum:_____

Father Information	Mother Information
Name:	Maiden Name:
Tribe:	Tribe:
Birth City:	Birth City:

Next of Kin

Name:_____ Phone#:_____
Address:_____Relationship:_____

Emergency Contact

Name:_____ Phone#:_____
Address:_____ Relationship:_____

Insurance and or Other Coverage

Medicaid Yes No	**Medicare** Yes No	**Private Insurance** Yes No	**Other** Yes No
Number:	Number: Part A Part B	Co. Name: Number:	Co. Name: Number:
Eligible From:	Eligible From:	Eligible From:	Eligible From:
Expiration Date:	Expiration Date:	Expiration Date:	Expiration Date:

Policy Holder Name:_____DOB:_____
Employers Name/Address:_____
Veteran: YES___ NO___ Division:_____Date of Service:_____

Medical History

This information is for office use only and will NOT affect your eligibility to receive Contract Health Services

Diabetes: Yes No	Heart Disease: Yes No	High Blood Pressure: Yes No
Allergies: Yes No	Asthma: Yes No	Arthritis: Yes No
High Cholesterol: Yes No	Mental Illness: Yes No	Smoking: Yes No

I certify the above information to be accurate and true to the best of my knowledge and authorize NWBSN to verify the accuracy of this application. I understand that all medical information will be kept confidential and authorize NWBSN to release any or all necessary medical information from provider for billing and payment purposes.

Applicants Signature: _____ Date: _____
(Or Guardian if under 18)

Office Use Only:	
Date Received:	Eligibility Status:

Privacy Act of 1974 Statement for Maintenance of Health Records

The purpose for requesting your personal medical history is to obtain information necessary for effective medical treatment. Your medical record contains what you tell the health care provider is wrong with you or how you feel. The health care provider writes (into your record) your family medical history as you answer the questions. Your answers could have an effect on the type of care you receive. Therefore, it is in your best interest to provide complete and correct information so that we will be able to carry out our responsibility of providing your proper care. The results of your physical examination, laboratory tests, medications, treatments, or surgical procedures you receive in Indian Health Service facilities are recorded in your medical record. Certain information is stored in the I.H.S. Data System for statistical purposes.
Indian Health Service personnel may not reveal the contents of your record without your wri8tten permission, except when they are permitted to do so by law. Examples of situations where we will release information without your prior written consent are:

1.Pursuant to the order of a court of competent jurisdiction;
2.Certain medical conditions (primarily communicable diseases) that must be reported to various health departments and other health statistical gathering centers;
3.To qualified organizations which provide health services to American Indians and Alaska Natives for the purposes of planning for or providing such services to conduct research and evaluation studies, to report to state agencies as required by state law to prepare for litigation on behalf of the federal government.
4.To third parties (other than the I.H.S) responsible for the payment of medical expenses incurred by the patient while being treated by the I.H.S medical staff or private providers under contract with the I.H.S.

Public Laws 83-568, 85-151, and 93-222 give the I.H.S the authority to collect and maintain health records. For a comprehensive list of situations in which IHS may release information from your records without your permission, you should see the Department of Health and Human Services Annual Publication of System of Records which is published annually in the Federal Register.

I have read and understand the Privacy Act information and do hereby give the Indian Health Service my authorization to collect payment and billing information from third parties on my behalf.

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Name *Date*