Data Entry _____
Verified _____
HRN _____

COWLITZ INDIAN TRIBE

Health Services Registration Short Form

☐ Update
☐ Other

Legal Name: _____ DOB: _____
Emergency Contact: _____
Physical Address: _____ Or: ☐Unsheltered ☐No Fixed Address
City: _____ State: _____ Zip: _____ County: _____

Primary Phone: _____ Permission to leave general message: ☐Yes ☐No
Secondary Phone: _____ Email: _____

PRIMARY INSURANCE INFORMATION

Medical Insurance: _____ Phone: _____
Address: _____ Effective Date: _____
Policy Holder: ☐Self ☐Spouse ☐Parent ☐Other: _____ ☐Purchased Through Health Plan Finder
Policy Holder Name (if other than self): _____
Policy Holder DOB: _____ Social Security No. (if other than self): _____
Employer Providing Coverage (if applicable): _____ Phone: _____
ID #: _____ Group #: _____ Rx Name/ID#: _____
Dental Insurance Name/ID#: _____
Optical Insurance Name/ID#: _____

AUTHORIZATIONS

_____ Initial here confirming you have been notified that most laboratory services will be performed and billed by a facility outside of the Cowlitz Indian Tribe (CIT) and you understand that you and/or your insurance provider(s) are responsible for costs associated with these services.

ALL CLIENTS/PATIENTS: My signature indicates, to the best of my knowledge, that all information provided is true and accurate. My signature authorizes the release of medical information necessary for diagnosis, treatment, and billing. I hereby authorize billing and payment of services, assign benefits otherwise payable to me to CIT, and request that payment be made to CIT directly. I agree to remit to CIT any payments sent directly to me for services provided by CIT.

Print Name: _____ Relationship to Patient: _____
Signature: _____ Date: _____