OSAGE NATION HEALTH SYSTEM
A Culture of Caring

New Patient Application

WahZhaZhe Health Center
715 Grandview
Pawhuska, OK 74056
918 287-9300

Please submit the requested documents with your completed application

Fax: 539-257-0717

or

registration@osagehealth.org

----Incomplete applications will not be considered----

- **Tribal Membership Card (Osage Members Only)**
- **Certificate Degree of Indian Blood (CDIB) or proof of Native American Descent from a federally recognized tribe of the U.S.**
- **Children under 18 years of age, using their parent's CDIB, A state issued birth certificate will be needed.**
- **Valid Picture ID or driver's license**
- **Health Insurance Cards** (Examples include Blue Cross/Blue Shield, Medicare A & B,
  Part D-Drug Plan, Medicare Replacement/Advantage Plan, Tricare, VA health card, or any other third-party coverage.)
- **Utility Bill-** (Examples: Gas, Water, and Rent Receipt. No cut-off notices.)

Attention Expectant Mothers: Along with the above information, submit your marriage license or notarized paternity affidavit, husband/boyfriend's picture ID, proof of pregnancy like the blood serum HCG test or ultrasound, and a signed Non-Beneficiary Acknowledgement form.

***As part of this registration, a Patient Benefits Coordinators will screen those patients who do not have insurance or any kind of third-party* coverage**

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Wah-Zha-Zhe Health Center New Patient Application

(Please do not leave any blanks)

Legal Last Name: _____First Name: _____ Middle Name: _____

Date of Birth: _____ Social Security #: _____ Gender: _____

List other names and Aliases used (if any): _____

Tribal Membership or Descendancy:_____Blood Quantum: _____

Please list other Tribe(s):_____Blood Quantum: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Birthplace of Patient: _____ Religious Preference: _____

Mailing Address: _____City: _____State: _____Zip: _____
Physical Address: _____City: _____State: _____Zip: _____
Primary Phone #: _____ Alternate Phone#: _____
Work phone #: _____Cell Phone#: _____
Patient's Father: _____
Last Name, First Name, City and State of Birth
Patient's Mother: _____
Maiden Last Name, First Name, City and State of Birth

Employment information:

Name of Employee: _____Company Name: _____

Company Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Employment status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired

**** **For Children under 18, please list the parents' or legal guardians' employers** ****

Do you have Internet access? Yes □ No □ E-mail address: _____
Internet access locations: (*Check all that apply*): Home □ Work □ Cell □ School □ Other _____
Do we have permission to send generic health information to your E-mail address? ☐ Yes ☐ No
What is your preferred method to receive appointment reminders?
(*Check one*): ☐ Phone ☐ E-mail ☐ Cell ☐ Letter
Would you be interested in Communicating via text? ☐ Yes ☐ NO
Are you a Migrant Worker? ☐ Yes ☐ No Are you Homeless? ☐ Yes ☐ No

What is your primary language of communication?
☐ English ☐ Tribal Language ☐ Spanish ☐ Sign Language
If other than English, would you need an interpreter? ☐ Yes ☐ No

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Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Next of Kin:

Name: _____ Phone: _____ Relationship: _____

Address: _____ City_____ State: _____ Zip: _____

MILITARY SERVICE INFORMATION

Branch of Service: _____ Vietnam Service indicated? ☐ Yes ☐ No Service

Entry Date: _____ Separation Date: _____ Connected? ☐ Yes ☐ No claim

Do you have a valid VA card? ☐ Yes ☐ NO Number: _____

Brief description of VA disability: _____

ADVANCE DIRECTIVE/LIVING WILL

(For our patients who are 18 years or older)

Do you have an Advance Directive (Living Will) in place? ☐ Yes ☐ NO

If you answered NO, would you like some information on the subject? ☐ Yes ☐ No

Please tell patient registration, your physician or nurse if you would like to know more about the Advance Directive (Living Will), and they will arrange for the Patient Benefits Coordinator to meet with you and answer your questions.

INSURANCE COVERAGE

If you answer YES to any of the following, please show card/cards to Patient Registration clerk

Private insurance: ☐ Yes ☐ NO Medicare A and /or B: ☐ Yes ☐ NO

Affordable Care Act: ☐ Yes ☐ NO Medicare Replacement/Advantage: ☐ Yes ☐ No

Oklahoma Sooner Care: ☐ Yes ☐ No Part D (Rx Plans): ☐ Yes ☐ No

The WahZhaZhe Health Center may disclose all or any part of the patient's record to any person or corporation which is or may be liable under contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charges, including but not limited to: hospital or medical service companies, workmen's compensation carriers, welfare funds or the patient's employer. The information authorized for release may include information which may be considered a communicable or venereal disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea and the Human Immune Deficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

I hereby assign to the clinic such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the clinic. I understand that this assignment applies only to medical services and supplies furnished to me during the time indicated below.

By signing below, ***I AUTHORIZE PAYMENT OF SUCH BENEFITS DIRECTLY TO WAH-ZHA-ZHE HEALTH CENTER.***

Patient Signature_____ **Date**_____

Parent or Legal Guardian_____ **Date**_____

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Notice of Privacy Practices for HIPAA

(Health Insurance Portability and Accountability Act) Privacy Rule

I hereby acknowledge receipt of the WahZhaZhe Notice of Privacy Practices at:

WahZhaZhe Health Center
715 Grandview
Pawhuska, OK 74056

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian/Personal Representative Date

_____ _____
Signature of Patient Registrar Date

For patients unable to acknowledge receipt

I hereby certify that the patient was unable to acknowledge receipt of the WZZHC Notice of Privacy Practices because of reason stated below:

Signature & title of Registrar _____ Date_____

For Office use only:

Patient Name	**Chart Number**

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Assignment of Benefits
&
Authorization to Furnish Information
Wah-Zha-Zhe Health Center
715 Grandview
Pawhuska, OK 74056

The WahZhaZhe Health Center may disclose all or any part of the patient's record to any person or corporation which is or may be liable under contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charges, including but not limited to: hospital or medical service companies, workmen's compensation carriers, welfare funds or the patient's employer.

The information authorized for release may include information which may be considered a communicable or venereal disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immune deficiency virus, also known as acquired immune deficiency syndrome (AIDS).

I hereby assign to the WahZhaZhe Health Center such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the WahZhaZhe Health Center. I understand that this assignment applies only to medical services and supplies furnished to me during the time indicated below.

I AUTHORIZE PAYMENT OF SUCH BENEFITS DIRECTLY
TO WahZhaZhe Health Center.

Patient or Proxy Signature_____
(if other than patient signature, please specify relationship to patient)

Date(s) of Service: _____

For Office Use Only:

Patient Name	Chart Number

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PRIVATE INSURANCE
POLICY HOLDER INFORMATION

Private Insurance: ☐ YES ☐ NO AFFORDABLE CARE ACT INSURANCE: ☐ YES ☐ NO

Policy Holder Information:
Last Name: _____ First Name: _____ Middle Name: _____
Date of Birth: _____ SSN #: _____ Phone #: _____
Mailing Address: _____City: _____State: _____Zip: _____

EMPLOYER INFORMATION FOR POLICY HOLDER

Name of Employer: _____ ☐ Full Time ☐ Part Time ☐ Self Employed

Employer's Address: _____City: _____ State: _____ Zip: _____

Please list by DOB or CHART NUMBER of any covered family members:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **6.** _____

OFFICE USE ONLY:

NAME OF INSURANCE COMPANY: _____

CLAIMS MAILING ADDRESS: _____

CITY, STATE, ZIP CODE: _____

PHONE NUMBER: _____

EFFECTIVE DATE: _____

COVERAGE: MEDICAL DENTAL VISION _____

GROUP NAME: _____ GROUP#: _____

POS MIN#: _____ GROUP#: _____

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PRIVACY OF CONSENT AUTHORIZATION OF MINORS

I/We the undersigned, parent, or legal guardians of the following minor(s):

1._____ Date of Birth _____
2._____ Date of Birth _____
3._____ Date of Birth _____
4._____ Date of Birth _____
5._____ Date of Birth _____
6._____ Date of Birth _____

I/We authorize any x-ray examination, anesthetic, dental, mental health, medical or surgical diagnosis or treatment by any member of the medical or nursing staff at WahZhaZhe Health Center that may be rendered to said minor under the general, specific, or special consent of

Name_____Relationship: _____
Name_____Relationship: _____
Name_____Relationship: _____
Name_____Relationship: _____

The temporary custodian of the minor(s). I/We authorize the medical or nursing staff of WahZhaZhe Health Center to call if any necessary consultation is at his/her discretion.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but it is given to encourage those persons who have temporary custody of the minor(s), and nursing and /or medical staff to exercise their best judgment as the requirements of such diagnosis, medical or dental treatment. This consent shall remain effective at any time they have him/her in their care unless revoked in writing and delivered to the WahZhaZhe Health Registration Department.

Parent/Legal Guardian_____ Date_____