COW CREEK BAND
OF UMPQUA TRIBE OF INDIANS

COW CREEK HEALTH & WELLNESS CLINICS

NEW ADULT REGISTRATION FORM

Please fill out this form as completely as possible.

Name *(Last, First, M.I.):*			**DOB:**
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Partnered ☐ Widowed			
Social Security Number:		**Preferred Name:**	
Gender: ☐ Male ☐ Female ☐ Other:	**Employment Status:**		
	Language:		**Tribally Enrolled:** ☐ No ☐ Yes
	Veteran: ☐ Yes ☐ No	**Tribal Enrollment Number:**	
Home Address:		**Mailing Address:**	
Cell Phone:		**Email:**	
Home Phone:		**Emergency Contact:**	
Work Phone:		**Emergency Contact Phone:**	
Primary Contact: ☐ Cell ☐ Home ☐ Work		**Relationship to Patient:**	
Employer's Name:			
Employer's Address:			
Ethnicity:	☐ American Indian/Alaskan Native ☐ Caucasian ☐ African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino ☐ Other:		
Primary Insurance ☐ Yes ☐ No			
Insurance Name:		**ID:**	**Group:**
Policy Holder Name:		**Policy Holder Date of Birth:**	
Secondary Insurance ☐ Yes ☐ No			
Insurance Name:		**ID:**	**Group:**
Policy Holder Name:		**Policy Holder Date of Birth:**	

I, the undersigned, being the patient or legal guardian/person having legal custody/or person otherwise having legal authorization to consent, freely give my consent to Cow Creek Health & Wellness Center (CCH&WC) and their agents, to examine and treat the patient registered/referenced above. I authorize CCH&WC to release any medical records that may be requested by a 3rd party payer for the purpose of paying for services rendered, and further authorize the payment from any such medical benefits be made directly to CCH&WC. By using insurance for this and other visits, I understand it is my responsibility to know the terms and conditions of my coverage and to provide a copy of the most current insurance card. I know I have the right to decline treatment recommended by the provider. If I am provided a service that is not covered by my insurance, or if my insurance coverage has lapsed, I will be responsible for the charges in full. I understand that if my Insurance has not paid after 45 days from the billing date that I may be billed directly. I acknowledge that I am subject to collections for non-payment' of any balances that I, as the guarantor, may owe. By signing below for acceptance of services, I am fully aware that I am financially responsible for all services provided for me by CCH&WC. If I am using Insurance, I understand CCH&WC will bill my Insurance and accept as payment In full, the amount the Insurance pays, with the exception of co-pays, deductibles, amounts designated as patient responsibility by the insurance, or non-covered services. In the event that my insurance sends me a check meant for my provider for services rendered, I am responsible for payment to the provider. I also understand that CCH&WC reserves the right to bill at a later date for any missed charges for the date of service. I have been offered a copy of the CCH&WC Privacy Policy and CCH&WC Patient Rights and Responsibilities.

_____ _____

Patient Signature Date

_____ _____

Legal Authorized Representative/Legal Guardian Signature Date

Sign Digitally