Gila River
HEALTH CARE

P. O. Box 38 Sacaton, Arizona 85147
Phone: (520) 562-3321
(602) 528-1200
Fax: (602) 528-1326

DATE: _____ H.R.#: _____

THE FOLLOWING INFORMATION IS REQUIRED TO ESTABLISH A MEDICAL CHART

FULL NAME: _____ Other Names: _____
(Last) (First)(M.I.) *(Maiden, Former, Nickname, Etc...)*

Birth Date: ____/____/____ Birth Place: _____ SS# _____-_____-_____

SEX: M☐/F☐

Current Physical Address: _____ Zip _____

Current Mailing Address: _____ Zip _____

Previous Address: _____ Zip _____ Date moved: _____

Telephone: _____ Alt. Telephone: _____

Marital Status: Married☐/Single☐/Divorced☐ Etc.☐

Internet Access: Y☐/N☐ Where: Home☐/Work☐

Homeless: Y☐/N☐ Migrant Worker: Y☐/N☐ Other Languages: _____

EMPLOYMENT INFORMATION:

Employers Name: _____ Title/Position: _____ # Years _____

Employers Address: _____ Full☐ P/T☐ Work Phone: _____

SPOUSE'S INFORMATION:

Name: _____ Employers Name: _____ # Years _____

Title/Position: _____ Full☐ P/T☐ Employers Address: _____

Work Phone: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Phone: _____ Address : _____ Zip: _____

NEXT OF KIN:

Name: _____ Relationship: _____

Phone: _____ Address : _____ Zip: _____

FAMILY HISTORY:

Father's Name: _____ Birth Place: _____ DOB _____

Father's Employer: _____ Title/Position: _____ Full☐ P/T☐

Employer's Address: _____ Phone: _____

Mother's Maiden Name: _____ Birth Place: _____ DOB _____

Mother's Employer: _____ Title/Position: _____ Full☐ P/T☐

Employer's Address: _____ Phone: _____

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NATIVE AMERICAN ELIGIBILITY:

Are you a member of a Federally Recognized Tribe? _____ Blood Quantum: _____
Name of tribe: _____ Enrollment # _____
Are you a descendent of a Federally Recognized Tribe? _____
Name of tribe: _____ Enrollment # _____

Is anyone in the Household attending college? _____ Who? _____
Where? _____ Full-Time ☐ P/T ☐

ARE YOU A VETERAN? YES ☐ NO ☐ Service Branch (Last): _____
Service Entry Date (Last): _____ Service Separation Date (Last): _____
Vietnam Service Indicated? YES ☐ NO ☐

MEDICAID INFORMATION (Please submit a copy of Medicaid card)

Medicaid: YES ☐ NO ☐ Eligibility Dates: _____ Medicaid # _____
Passport Provider: _____ Coverage: _____ Full: _____ Basic: _____

MEDICARE INFORMATION (Please submit a copy of Medicare card)

Medicare: YES ☐ NO ☐ Medicare # _____ Plan # _____
Prescription Plan Name: _____ Effective Dates For Parts A: _____ B: _____ D: _____

PRIVATE INSURANCE (Please submit a copy of insurance information)

Name of Primary Insured: _____ Birth Date: _____ S.S. # _____
Company Name: _____ Phone # _____
Address: _____ City: _____ State: _____ Zip: _____
Group Name: _____ Group # _____ Effective Date: _____ Exp.Date: _____

LIST ALL HOUSEHOLD MINORS IN THE HOME:

NAME *(Last, First, M.I.)*	RELATIONSHIP	BIRTHDATE	INS Y/N	HEALTH RECORD #

(Updated 7/1/20)

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PLEASE READ BEFORE SIGNING:

Privacy Act of 1974 PUBLIC LAW 93-579, I UNDERSTAND THAT THE INFORMATION GIVEN BY ME AND/OR COLLECTED IS NECESSARY FOR THE Indian Health Services to provide for my well being. Furthermore, I have been informed that my records shall not be disclosed to any other agency or person without my signed consent.

Assignment of Benefits (AOB):

I understand the GILA RIVER HEALTH CARE has the right of recovery and reimbursement from certain third parties for medical expenses paid on my behalf to the extent that such costs are covered. Further, I understand that GILA RIVER HEALTH CARE may bring a claim or cause of action against the third party for recovery of such medical expenses.

Therefore, I agree as follows:

1. To assign to the Gila River Health Care any claim of cause of action against the third person to the extent of the medical expenses paid, or any portion thereof.
2. To furnish such information as may be requested concerning the circumstances giving rise to the injury or disease for which care and treatment is being given and concerning any action instituted or to be instituted by or against a third party.
3. To notify the Gila River Health Care of a settlement with, or an offer of settlement from a third person and
4. To cooperate in the prosecution of all claims and actions by the Gila River Health Care against such third person.

I hereby authorize GILA RIVER HEALTH CARE to furnish medical information including information related to diagnosis of Mental Health, Substance Abuse, HIV/AIDS, Sexually Transmitted Disease, Payment of Medical Bills and Other information to Tribal Legal Department, Insurance Carriers, and other Third Party Payers' concerning my illness and treatment, and hereby assign all payments for medical services rendered to myself or my dependents. (This AOB authorization is in effect until revoked)

I certify the above information provided to be accurate and true to the best of my knowledge and authorize GILA RIVER HEALTH CARE to verify the accuracy of this application:

Print Name:_____ Signature:_____ Date: _____

SCANNED DOCUMENTS Click To Upload Docs.	Y/N	SCANNED DOCUMENTS	Y/N
Photo Identification Card Identification or Drivers License			
Tribal Enrollment: Approval Letter, CDIB, Photo ID			
Birth Certificate: Original or Certified Copy			
Social Security Card: Original			
Medicaid, Medicare, or Private Insurance Information & Cards			

(Updated 10/10/20)