MACT Mariposa Amador Calaveras Tuolumne HEALTH BOARD INC
A Non-Profit Tribal Corporation

New Patient Registration (Child Packet)

Section 1. Instructions

Return completed forms[1] and supporting documentation to your local MACT Clinic or:

Mail: MACT Health Board, Inc.
Health Information Management
PO Box 939
Angels Camp, CA 95222

Fax: (209) 674-6200
Email: registration@macthealth.org[2]
Phone: (209) 754-6262

Registration forms and supporting documentation will be reviewed for completeness and processed in the order received. **Incomplete forms will not be processed and will delay your ability to establish care.** Once registration forms have been processed, you will be contacted to schedule your first appointment with each of the selected services in Section 2.

[1] For your convenience, this registration packet can be completed electronically by downloading the latest version of Adobe Acrobat Reader at https://get.adobe.com/reader/. Please note: MACT Health Board, Inc. does not endorse this product or Adobe Systems Incorporated.

[2] Information transmitted over the Internet may be at risk for loss of confidentiality. MACT Health Board, Inc. does not recommend sending confidential information, such as Social Security numbers over the Internet or via e-mail.

Section 2. Locations and Services

Please select the location and services that are of interest. Not all services are offered in all locations. A representative will contact you with alternative options if we are unable to accommodate your primary preference(s).

Locations: ☐ Jackson ☐ Mariposa ☐ San Andreas ☐ Sonora

Services: ☐ Behavioral Health ☐ Dental ☐ Medical

Specialty: ☐ Native American Diabetic Program ☐ Neurology[1] ☐ Optometry[1] ☐ Orthopedics[1] ☐ Podiatry[2]

[1] Offered in San Andreas [2] Offered in Jackson

Section 3. Waitlist

Note: Priority access is given to American Indian and Alaskan Native patients.

Are you interested in being added to a waitlist if your primary preference(s) cannot be accommodated at this time? ☐ Yes ☐ No (If No, please contact your insurance company and request to change your PCP)

Section 4. Care, Custody, Control, and Conduct

Do any of the following apply? (Check all that apply. Additional supporting documentation required.)

☐ Adoption
☐ Caregiver
☐ Court Ordered Parental Rights
☐ Emancipated Minor
☐ Foster Care
☐ Group Home
☐ Guardian ad Litem
☐ Kinship Care
☐ Legal Guardian
☐ Legal Name Change
☐ Self-sufficient Minor
☐ Tribal Customary Adoption

Section 5. Patient Information

Patient's Legal Name: _____ _____ _____
First Middle Last

Gender Identity: ☐ Male ☐ Female ☐ Other: _____ **Date of Birth**: _____

Social Security Number[1]: _____ **Primary Language**: _____

[1] Failure to provide a social security number (SSN) or individual taxpayer identification number (ITIN) may prevent your ability to establish care and/or continue to receive services at MACT Health Board, Inc.

Physical Address: _____

City: _____ **State**: _____ **Zip**: _____

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____ _____ _____
Home Work Cell

Email Address: _____ **Employer**: _____

Preferred Contact: ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email **Okay to leave a detailed message?** ☐ Yes ☐ No

American Indian or Alaskan Native Eligibility

_____ _____ _____ _____
Tribe of Membership | Roll Number | Certificate of Indian Blood (CIB) | State Where Enrolled

Race and Ethnicity

Please check one box that best describes your race or ethnicity.

☐ American Indian/Alaska Native
☐ Black or African American
☐ Hispanic or Latino[1]
☐ White
☐ Multiple Races[2]

Asian
☐ Multiple Asian[3]
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Indian
☐ Japanese
☐ Korean
☐ Laotian
☐ Other Asian
☐ Vietnamese

Pacific Islander
☐ Multiple Pacific Islander[4]
☐ Guamanian
☐ Hawaiian
☐ Samoan
☐ Other Pacific Islander

[1] If you identify with Hispanic or Latino (alone or in combination with any other race)
[2] If you identify with more than one race that is not Hispanic or Latino, select Multiple Races.
[3] If you identify with more than one Asian ethnicity, select Multiple Asian.
[4] If you identify with more than one Pacific Islander ethnicity, select Multiple Pacific Islander.

Section 6. Parent or Legal Guardian Information

Primary Parent or Guardian Name: _____

Gender Identity: ☐ Male ☐ Female ☐ Other: _____ **Date of Birth**: _____

Relationship to Patient:

☐ Parent	☐ County Case Worker	☐ Guardian ad Litem	☐ Other:
☐ Adoptive Parent	☐ Court-ordered Custodial Parent	☐ Legal Guardian	
☐ Caregiver	☐ Foster Care Parent	☐ Social Worker	_____

Social Security Number: _____ **Primary Language**: _____

Physical Address: _____

City: _____ **State**: _____ **Zip**: _____

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____ _____ _____
Home Work Cell

Email Address: _____ **Employer**: _____

Preferred Contact: ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email **Okay to leave a detailed message?** ☐ Yes ☐ No

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Secondary Parent or Guardian Name: _____

Gender Identity: ☐ Male ☐ Female ☐ Other: _____ **Date of Birth**: _____

Relationship to Patient:

☐ Parent	☐ County Case Worker	☐ Guardian ad Litem	☐ Other:
☐ Adoptive Parent	☐ Court-ordered Custodial Parent	☐ Legal Guardian	
☐ Caregiver	☐ Foster Care Parent	☐ Social Worker	_____

Social Security Number: _____ **Primary Language**: _____

Physical Address: _____

City: _____ **State**: _____ **Zip**: _____

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone: _____ _____ _____
Home Work Cell

Email Address: _____ **Employer**: _____

Preferred Contact: ☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email **Okay to leave a detailed message?** ☐ Yes ☐ No

Section 7. Insurance Information

Do you have insurance? ☐ Yes ☐ No **Are you interested in our sliding fee scale?** ☐ Yes ☐ No

Medical Insurance

Primary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Guarantor Name: _____ **Date of Birth**: _____

Secondary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Guarantor Name: _____ **Date of Birth**: _____

Tertiary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Guarantor Name: _____ **Date of Birth**: _____

Dental Insurance

Primary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Guarantor Name: _____ **Date of Birth**: _____

Secondary Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Guarantor Name: _____ **Date of Birth**: _____

Vision Insurance

Insurance Company: _____ ☐ N/A

Policy Number: _____ **Group Number**: _____

Guarantor Name: _____ **Date of Birth**: _____

Section 8. Financial Agreement

Financial Policy. MACT Health Board, Inc. "MACT" follows regulations and laws set by Indian Health Services and the State of California. Depending on your status, you will be financially responsible for all, part, or none of the services performed at any of our clinics, as well as any and all costs associated with the collection of services rendered. Proof of eligibility for Medicare, Medi-Cal, and contracted insurance companies is the responsibility of the patient. It is your responsibility to know your insurance plan, covered benefits, and co-pays and deductibles. MACT will submit insurance claims for patients whose insurance is provided by a health plan in which it contracts however; MACT expects same day payment for all co-payments, deductibles, and non-covered services. In cases where patients are required to pay cash for an appointment, a close approximation of the cost must be paid on the day services are rendered. If the actual cost of the treatment amount is different, the difference will be billed or refunded to the patient.

Authorization to Release Information and Assignment of Benefits. MACT has my permission to release information as needed for insurance processing and for my insurance to release payment to MACT Health Board, Inc.

Medicare Authorization: I agree that payment of authorized Medicare benefits be made on my behalf to MACT for any services provided. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I will be responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible amounts are based upon the charge determination of the Medicare carrier.

Section 9. Emergency Contact Information

Emergency Contact's Name: _____ _____ _____
First Middle Last

Relationship to Patient: _____ **Phone Number**: _____

☐ I decline to provide an emergency contact

Section 10. Pharmacy

MACT Health Board, Inc. "MACT" participates in the 340B Drug Pricing Program which may increase access and convenience to prescription drugs for our patients. Are you interested in changing your pharmacy to a pharmacy that has contracted with MACT for 340B pricing? ☐ Yes ☐ No

Preferred Pharmacy: _____

Phone: _____ **Fax**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Section 11. Acknowledgements and Authorization

By signing this document, you certify that the information provided throughout this form is true and accurate. Additionally, you indicate receipt, understanding, and acceptance of the following MACT Health Board, Inc. forms and policies:

- Appointment Cancellations and No-Shows
- Financial Agreement
- Notice of Privacy Practices
- Pain Management Agreement
- **For Dental Patients**: Dental Board of California's Dental Materials Fact Sheet

Furthermore, you acknowledge and accept that MACT Health Board, Inc. employs and uses the services of **Non-Physician Medical Practitioners (NMPs)** such as Physicians Assistants and Nurse Practitioners. You may be treated by an NMP.

I/we certify that I/we have read and understand the above information to the best of my/our knowledge. The undersigned patient, and/or responsible party gives permission for MACT Health Board, Inc. to administer healthcare treatment and advice as necessary.

_____	_____	____/____/_____	_____
Print Name of Patient	Signature of Patient[1]	MM DD YYYY	Relationship to Patient
_____	_____	____/____/_____	_____
Print Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian[2]	MM DD YYYY	Relationship to Patient

[1] The signature of the patient is only required if s/he is legally capable of consenting to her/his own care and/or treatment.

[2] If this form is completed and signed by a non-custodial parent, including but not limited to a legal guardian, person(s) having legal custody of the minor, or a caregiver of the child who is a relative of the child and who may authorize medical care and dental care under Section 6550 of the California Family Code, supporting legal documentation is required.

Section 12. Further Instructions

Please return the following forms to MACT Health Board, Inc. as instructed in Section 1:

☐ Pages 1-6 of the Patient Registration Packet and supporting documentation

☐ Health History Questionnaire

☐ **For Medicare Patients**: Medicare Secondary Payer Questionnaire

☐ Authorization for Use or Disclosure of Protected Health Information, optional

☐ Authorization for Third-Party Consent to Treatment of Minor Lacking Capacity to Consent, optional

☐ Permission to Verbally Discuss Protected Health Information, optional

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Health History Questionnaire (Child)

Patient Name: _____ **Date**: _____

Date of Birth: _____ **MRN**: _____
Internal Use Only

1. Most Recent **Physician's** Name: _____ ☐ None

   Phone: _____ Fax: _____

   Address: _____

   City: _____ State: _____ Zip: _____

2. Most Recent **Dentist's** Name: _____ ☐ None

   Phone: _____ Fax: _____

   Address: _____

   City: _____ State: _____ Zip: _____

3. Most Recent **Optometrist's** Name: _____ ☐ None

   Phone: _____ Fax: _____

   Address: _____

   City: _____ State: _____ Zip: _____

4. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

   If Yes, for what? _____

Medications

5. Are you taking any medication including non-prescription drugs? ☐ Yes ☐ No
   If yes, please list name(s) and dosage:

   Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

6. Do you take **BISPHOSPHONATE** medications? ☐ Yes ☐ No ☐ Unsure

Household

7. Please list all those living in your/child's home.

Name	Relationship to You/Your Child	Date of Birth	Health Problems

8. Are there siblings not listed? If so, please list their names, ages, and where they live.

9. What is your/child's living situation if not with both biological parents?

   ☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody ☐ Lives with foster family

10. If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History

☐ Don't know birth history

11. Birth weight: _____ ☐ Unsure
12. Was the baby born at term? ☐ Yes ☐ No ☐ Unsure
    a. If no, how many weeks along? _____
13. Was the delivery ☐ vaginal ☐ cesarean? ☐ Unsure
    a. If cesarean, why? _____
14. Were there any prenatal or neonatal complications? ☐ Yes ☐ No ☐ Unsure
    a. If yes, explain: _____
15. Was a NICU stay required? ☐ Yes ☐ No ☐ Unsure
    a. If yes, explain: _____
16. During pregnancy, did mother: ☐ Use tobacco ☐ Drink alcohol ☐ Use drugs or medications ☐ Use prenatal vitamins
17. Was initial feeding: ☐ formula ☐ breast milk?
18. How long were you/your child breastfed? _____
19. Did you/your baby go home with mother from the hospital? ☐ Yes ☐ No ☐ Unsure

General

20. Do you consider yourself/your child to be in good health? ☐ Yes ☐ No ☐ Unsure
21. Do you/your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ Unsure
22. Have you/your child had any surgery? ☐ Yes ☐ No ☐ Unsure
23. Have you/your child ever been hospitalized? ☐ Yes ☐ No ☐ Unsure
24. Are you/your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ Unsure
25. Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ Unsure

Allergies

26. Are you aware of having an allergic or adverse reaction to any medication, food or substance? ☐ Yes ☐ No

☐ Sulfa drugs	☐ Metals (nickel, mercury, etc.)	☐ Sedatives
☐ Barbiturates	☐ Penicillin or other antibiotics	☐ Aspirin
☐ Iodine	☐ Local anesthetics (e.g. Novocain)	☐ Latex

Medication/Food/Substance: _____ ☐ Allergic ☐ Adverse

Medication/Food/Substance: _____ ☐ Allergic ☐ Adverse

Medication/Food/Substance: _____ ☐ Allergic ☐ Adverse

Past History and Current Conditions

27. Indicate which of the following you/your child have had, or have at present (**check all that apply**):

- ☐ Heart (surgery, disease, attack)
- ☐ Chest pain
- ☐ Congenital heart disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Mitral valve prolapse
- ☐ Artificial heart valve
- ☐ Heart pacemaker
- ☐ Arthritis/rheumatism
- ☐ Swollen ankles
- ☐ Stroke
- ☐ Diet (special/restricted)
- ☐ Obesity
- ☐ Artificial joints (hip, knee, etc.)
- ☐ Kidney disease or urologic malformations
- ☐ Drug or alcohol use/abuse
- ☐ Tobacco use
- ☐ Thyroid or other endocrine problems
- ☐ Ulcers
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Tuberculosis
- ☐ Asthma, bronchitis, or pneumonia
- ☐ Latex sensitivity
- ☐ Allergies or hives
- ☐ Nasal allergies
- ☐ Sinus trouble
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Tumors/cancer
- ☐ Anemia or bleeding problem
- ☐ Malignancy/bone marrow transplant
- ☐ Hepatitis A, B, C
- ☐ Sexually transmitted infection
- ☐ AIDS
- ☐ HIV
- ☐ Cold sores/fever blisters
- ☐ Blood transfusion
- ☐ Hemophilia
- ☐ Sickle cell disease
- ☐ Bruise easily
- ☐ Liver disease
- ☐ Neurological disorders and/or convulsions
- ☐ Epilepsy or seizures
- ☐ Fainting or dizzy spells
- ☐ Frequent headaches
- ☐ Nervousness/anxiousness
- ☐ Psychiatric/psychological care
- ☐ ADHD/anxiety/mood problems/depression
- ☐ Chickenpox
- ☐ Frequent ear infections
- ☐ Problems with ears of hearing
- ☐ Problems with eyes or vision
- ☐ Organ transplant
- ☐ Frequent abdominal pain
- ☐ Constipation requiring doctor visits
- ☐ Recurrent urinary tract infections and problems
- ☐ Congenital cataracts/retinoblastoma
- ☐ Metabolic/genetic disorders
- ☐ Bed-wetting (after 5 years old)
- ☐ Sleep problems; snoring
- ☐ Chronic or recurrent skin problems (acne, eczema)
- ☐ History of serious injuries/fractures/concussions
- ☐ Developmental delay
- ☐ Dental decay
- ☐ History of family violence
- ☐ Other: _____

For Females

- ☐ Problems with your/her periods
- ☐ Has had first period
- ☐ Age of first period: _____
- ☐ Pregnancy
- ☐ Nursing
- ☐ Taking birth control pills

Biological Family Medical History

28. Do any of the following conditions run in your family? (**check all that apply)**

☐ None
☐ Childhood hearing loss
☐ Nasal allergies
☐ Asthma
☐ Tuberculosis
☐ Heart disease (before age 55)
☐ High cholesterol/takes cholesterol medication
☐ Anemia
☐ Bleeding disorder
☐ Dental decay
☐ Cancer
☐ Liver disease
☐ Kidney disease
☐ Diabetes (before age 55)
☐ Bed-wetting (after age 10)
☐ Obesity
☐ Epilepsy or convulsions
☐ Alcohol abuse
☐ Drug abuse
☐ Mental illness/depression
☐ Developmental disability
☐ Immune problems, HIV, or AIDS
☐ Tobacco Use
☐ Other: _____

Immunizations

29. Please provide the approximate dates of the following immunizations or select ☐ Unknown

Tetanus: _____ (Month) _____ (Year) Influenza: _____ (Month) _____ (Year) Pneumonia: _____ (Month) _____ (Year)

Present Dental Conditions, Treatments, and Appliances

30. Do your gums bleed while flossing or brushing? ☐ Yes ☐ No
31. Do you experience tooth sensitivity to hot/cold foods/liquids? ☐ Yes ☐ No
32. Do you experience tooth sensitivity to sweet/sour foods/liquids? ☐ Yes ☐ No
33. Are you experiencing the presence of sores or lumps in or near your mouth? ☐ Yes ☐ No
34. Are you experiencing pain in a specific location? ☐ Yes ☐ No
35. Do you have a history of head, neck or jaw injuries? ☐ Yes ☐ No
36. Are you experiencing jaw pain (joint, ear, side of face)? ☐ Yes ☐ No
37. Are you having difficulty opening or closing? ☐ Yes ☐ No
38. Do you bite your lips and/or cheeks frequently? ☐ Yes ☐ No
39. Do you experience jaw clicking? ☐ Yes ☐ No
40. Do you have difficulty chewing? ☐ Yes ☐ No
41. Do you experience frequent headaches? ☐ Yes ☐ No
42. Do you clench your teeth? ☐ Yes ☐ No
43. Do you grind your teeth? ☐ Yes ☐ No
44. Have you experienced prolonged bleeding? ☐ Yes ☐ No
45. Have you undergone orthodontic treatment? ☐ Yes ☐ No
46. Do you have full or partial dentures? ☐ Yes ☐ No
47. Do you snore while sleeping? ☐ Yes ☐ No
48. In the past, have you had to take an antibiotic before dental treatment? ☐ Yes ☐ No

Vision History

49. When was your last eye exam? _____ ☐ N/A
50. Do you wear glasses? ☐ Yes ☐ No
51. Do you have blurry vision? ☐ Yes ☐ No
52. Have you ever had any eye surgery in the past? ☐ Yes ☐ No
53. Have you ever had any of the following symptoms? ☐itching ☐burning ☐tearing ☐pain ☐flashes ☐floaters
54. Do you have any disease, condition, or problem not listed above? ☐ Yes ☐ No

If Yes, please explain: _____

Acknowledgement

I understand the above information is necessary to provide me with medical, dental, behavioral health, and/or vision care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

Additionally, if I ever have any changes in my personal information, health status, or my medication, I will inform my provider(s) at my next appointment, at the latest.

_____	_____	____/____/_____	_____
Print Name of Patient	Signature of Patient[1]	MM DD YYYY	Relationship to Patient
_____	_____	____/____/_____	_____
Print Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian[2]	MM DD YYYY	Relationship to Patient

[1] The signature of the patient is only required if s/he is legally capable of consenting to her/his own care and/or treatment.
[2] If this form is completed and signed by anyone other than a custodial parent(s) of a minor, including but not limited to a legal guardian(s), person(s) having legal custody of the minor, or a caregiver of the child who is a relative of the child and who may authorize medical care and dental care under Section 6550 of the California Family Code, supporting legal documentation is required.

For Internal Use Only

HT: **WT:** **BP:** / **P:** **TEMP:** **BG:** **AGE:**

Reviewed By: _____ Date: _____