MACT Mariposa Amador Calaveras Tuolumne HEALTH BOARD INC

A Non-Profit Tribal Corporation

Adult Patient Registration

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.

Locations and Services

Please select the location and services that are of interest. Not all services are offered in all locations. Some services may be limited to American Indian/Alaska Native patients-only. 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: ☐ American Indian/Alaska Native Diabetic Program[3] ☐ Chiropractic[1] ☐ Massage Therapy[1, 3]
☐ Neurology[1] ☐ Optometry[1] ☐ Orthopedics[1] ☐ Podiatry[2]

[1] Offered in San Andreas [2] Offered in Jackson [3] Only available to American Indian/Alaska Native Patients

Waitlist

Note: Priority access is given to American Indian and Alaska 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)

Pain Management Agreement

MACT Health Board, Inc. is not a pain management clinic. I understand I will not be seen for pain management. _____
Initial

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.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Veteran Status**: ☐ Yes ☐ No

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 Native Alaskan 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.

Insurance Infomation

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**: _____

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Secondary Insurance Company: _____ ☐ N/A

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

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Tertiary Insurance Company: _____ ☐ N/A

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

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Dental Insurance

Primary Insurance Company: _____ ☐ N/A

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

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Secondary Insurance Company: _____ ☐ N/A

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

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Vision Insurance

Insurance Company: _____ ☐ N/A

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

Subscriber Name: _____ **Date of Birth**: _____ **SSN**: _____

Insurance Card(s)

If you have insurance, MACT Health Board, Inc. requires a copy of the front and back of your insurance card(s) for insurance eligibility/verification purposes, as well as prescription drug-related matters. Please attach a copy of the **front and back** of your insurance card(s) with this packet. **If you are unable to provide a copy of your insurance card(s) with this registration packet, you must bring them to your first appointment.**

Prescription Drug Coverage

Do you have a separate insurance card for prescription drug coverage? ☐ Yes ☐ No

If yes, please attach a copy of the **front and back** of your insurance card(s) to this packet or bring them to your first appointment.

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.

Emergency Contact Information

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

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

☐ I decline to provide an emergency contact

Advance Health Care Directive

MACT Health Board, Inc. is required to offer all new patients who are **eighteen years or older or an emancipated minor** an Advance Health Care Directive however; patients are not required to complete an advance health care directive. Are you interested in receiving an advance health care directive?

☐ Yes ☐ No ☐ I have an advance directive (provide a copy)

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**: _____

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
- Patient Rights and Responsibilities
- **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	Today's Date	Relationship to Patient
_____	_____	___/___/____	_____
Print Name of Authorized Representative	Signature of Authorized Representative[1]	Today's Date	Relationship to Patient

[1]If this form is completed and signed by an authorized representative, supporting legal documentation is required.

Further Instructions

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

☐ Pages 1-5 of the Patient Registration Packet
☐ Health History Questionnaire (Adult)
☐ **For Medicare Patients**: Medicare Secondary Payer Questionnaire
☐ Authorization for Use or Disclosure of Protected Health Information, optional
☐ Permission to Verbally Discuss Protected Health Information, optional

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Adult Health History Questionnaire

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: _____

6. Do you take **BISPHOSPHONATE** medications? ☐ Yes ☐ No ☐ Not sure

Past or Present Conditions

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

- ☐ Heart (surgery, disease, attack)
- ☐ Chest pain/angina
- ☐ Congenital heart disease
- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Low Blood pressure
- ☐ High Cholesterol
- ☐ Mitral valve prolapse
- ☐ Artificial heart valve
- ☐ Heart pacemaker
- ☐ Arthritis/rheumatism
- ☐ Swollen ankles
- ☐ Joint pain/swelling
- ☐ Stroke
- ☐ Diet (special/restricted)
- ☐ Obesity
- ☐ Artificial joints (hip, knee, etc.)
- ☐ Osteoporosis
- ☐ Kidney disease or urologic malformations
- ☐ Fatigue/frequently tired
- ☐ Thyroid or other endocrine problems
- ☐ Ulcers/other stomach troubles
- ☐ Diabetes
- ☐ Difficulty breathing
- ☐ Glaucoma
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Tuberculosis
- ☐ Asthma, bronchitis, or pneumonia
- ☐ Hay fever/allergies
- ☐ Latex sensitivity
- ☐ Allergies or hives
- ☐ Nasal allergies
- ☐ Sinus trouble
- ☐ Recent weight changes
- ☐ Radiation therapy
- ☐ Chemotherapy
- ☐ Tumors/cancer
- ☐ Leukemia
- ☐ 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
- ☐ Mental/Nervous Disorder
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ ADHD
- ☐ Organ transplant
- ☐ Frequent abdominal pain
- ☐ Constipation requiring doctor visits
- ☐ Recurrent urinary tract infections and problems
- ☐ Congenital cataracts/retinoblastoma
- ☐ Metabolic/genetic disorders
- ☐ Sleep problems; snoring
- ☐ Chronic or recurrent skin problems (acne, eczema)
- ☐ Developmentally Disabled
- ☐ Dementia
- ☐ Autism
- ☐ Special Needs
- ☐ Other: _____

Allergies

8. 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

Social History

9. Do you use alcohol or recreational drugs (Cocaine, Marijuana, Methamphetamine, etc.)? ☐ Yes ☐ No
   If so what kind and how often?

Substance: _____ Frequency of Use: _____

Substance: _____ Frequency of Use: _____

10. Do you smoke or chew tobacco? ☐ Yes ☐ No
11. Do you drink caffeine? ☐ Yes ☐ No
12. Do you have a history of domestic violence? ☐ Yes ☐ No

Surgeries and Hospitalizations

13. Have you been hospitalized for any surgical operation or serious illness within the last five (5) years?
    ☐ Yes ☐ No
    a. If Yes, list all surgeries and/or serious illnesses and the year they were completed below:

Surgery/Illness: _____ Year: _____

Surgery/Illness: _____ Year: _____

Family Medical History

14. Do any of the following conditions run in your family?

☐ None	☐ Hypertension	☐ Stroke
☐ Diabetes	☐ Heart attack	☐ Cancer

☐ Other: _____

Immunizations

15. Please indicate the approximate dates of the following immunizations:

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

Women's Health

16. Are you pregnant? ☐ Yes ☐ No ☐ Not Sure
17. Are you nursing? ☐ Yes ☐ No
18. Are you taking birth control pills? ☐ Yes ☐ No
19. When did you last have a pap smear? _____
    a. Where was your pap smear performed?

       Physician's Name: _____ ☐ None

       Phone: _____ Fax: _____

       Address: _____

       City: _____ State: _____ Zip: _____
20. When did you last have a mammogram?_____
    a. Where was your mammogram performed?

       Physician's Name: _____ ☐ None

       Phone: _____ Fax: _____

       Address: _____

       City: _____ State: _____ Zip: _____

Preventive Care

21. When was the date of your last physical? _____ ☐ None
22. **Adults age 35 and older**:
    a. When was your last cholesterol lab test? _____ ☐ None
23. **Adult men over age 50 only**:
    a. When was the date of your last prostate exam? _____ ☐ None
24. **Adults over age 50 only**:
    a. When was your last colonoscopy? _____ ☐ None
25. **Adults over age 65 only**:
    a. When was your last DEXA scan (osteoporosis screening)? _____ ☐ None

Present Dental Conditions, Treatments, and Appliances

26. Do your gums bleed while flossing or brushing? ☐ Yes ☐ No
27. Do you experience tooth sensitivity to hot/cold foods/liquids? ☐ Yes ☐ No
28. Do you experience tooth sensitivity to sweet/sour foods/liquids? ☐ Yes ☐ No
29. Are you experiencing the presence of sores or lumps in or near your mouth? ☐ Yes ☐ No
30. Are you experiencing pain in a specific location? ☐ Yes ☐ No
31. Do you have a history of head, neck or jaw injuries? ☐ Yes ☐ No
32. Are you experiencing jaw pain (joint, ear, side of face)? ☐ Yes ☐ No
33. Are you having difficulty opening or closing? ☐ Yes ☐ No
34. Do you bite your lips and/or cheeks frequently? ☐ Yes ☐ No
35. Do you experience jaw clicking? ☐ Yes ☐ No

36. Do you have difficulty chewing? ☐ Yes ☐ No
37. Do you experience frequent headaches? ☐ Yes ☐ No
38. Do you clench your teeth? ☐ Yes ☐ No
39. Do you grind your teeth? ☐ Yes ☐ No
40. Have you experienced prolonged bleeding? ☐ Yes ☐ No
41. Have you undergone orthodontic treatment? ☐ Yes ☐ No
42. Do you have full or partial dentures? ☐ Yes ☐ No
43. Do you snore while sleeping? ☐ Yes ☐ No
44. In the past, have you had to take an antibiotic before dental treatment? ☐ Yes ☐ No

Vision History

45. When was your last eye exam? _____ ☐ N/A
46. Do you wear glasses? ☐ Yes ☐ No
47. Do you have blurry vision? ☐ Yes ☐ No
48. Have you ever had any eye surgery in the past? ☐ Yes ☐ No
49. Have you ever had any of the following symptoms? ☐itching ☐burning ☐tearing ☐pain ☐flashes ☐floaters
50. 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	MM DD YYYY	Relationship to Patient
_____	_____	___/___/____	_____
Print Name of Authorized Representative	Signature of Authorized Representative[1]	MM DD YYYY	Relationship to Patient

[1]If this form is completed and signed by an authorized representative, supporting legal documentation is required.

For Internal Use Only

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

Reviewed By: _____ Date: _____