SHINGLE SPRINGS Health & Wellness Center
Healthcare for All
SHINGLE SPRINGS HEALTH & WELLNESS CENTER
5168 Honpie Road
Placerville, CA 95667
Phone: 530-387-4975
www.sshwc.org

Shingle Springs Health & Wellness Clinic

Contract Health Services

REGISTRATION FORM

RPMS#

Legal Name_____
Last *First* *Full Middle Name*

Sex_____ Social Security Number_____ Birth date_____

Marital Status_____ Spouse's Name_____

Address_____ _____ _____ _____
City *State* *Zip*

City & State of birth_____ When did you move here?_____

Phone _____ _____ _____
Home *Work* *Cell/Message*

Employer_____
Company Name Address

Spouse's Employer_____
Company Name Address

Father's Name _____ Place of birth_____
Last *First* *City* *State*

Mother's Maiden Name_____ Place of birth_____
Last *First* *City* *State*

Are you a college student? _____ if yes, Full Time ____ Part Time____

Veteran _____ Religious Preference_____

***Emergency Contact**

Name_____ Phone_____

Address_____ Relationship to Patient_____

***Next of Kin**

Name_____ Phone_____

Address_____ Relationship to Patient_____

***Need to be different individuals**

Insurance Information

Medi-Cal (Medicaid)

Have you applied for Medi-cal recently? ☐Yes ☐No Are you eligible for Medi-cal? ☐Yes ☐No

Date of eligibility:_____ or Denial Date:_____

I.D. Number_____

Medicare

Check all that apply ☐Part A ☐Part B

Medicare Number _____ Suffix _____ Effective Date _____

Insurance: ☐Medical ☐Dental ☐Vision ☐Prescriptions

Insurance _____ Policy Holder _____

Policy Number _____ Policy Holder Birth Date _____

Group Number _____ Policy Holder Social Security Number_____

Effective Date _____

I certify that the information that you have provided to Shingle Springs Tribal Health Program staff is complete an accurate. I understand that if any information should change, it is my responsibility to provide Shingle Springs Tribal Health Program with all updated information.

I understand that if Shingle Springs Tribal Health Program makes unnecessary or improper payments on my behalf based on the information I provided, I may be liable for such payment, and I may be ineligible for Shingle Springs Tribal Health Program Contract health Services (CHS) in the future.

I assign to Shingle Springs Tribal Health Program any medical, dental and/or behavioral health benefits that I am entitled to under the terms of my health coverage, in whole or in part, of the services paid for or provided by Shingle Springs Tribal Health Program. I authorize the release of any medical information necessary to process my submitted claim.

_____ _____

Printed Name and Date ***Signature of Patient or Guardian***

Office Use Only

Enrolled? ☐Yes ☐No Roll Number _____ CDIB_____