OFFICE USE Date mailed _____ Date Returned _____ Chart _____

CITIZEN POTAWATOMI NATION BEHAVIORAL HEALTH
2307 S. GORDON COOPER DR., SHAWNEE, OK 74801
PHONE 405-214-5101 FAX 405-878-5846

INTAKE FORM

1. Please bring the following or provide colored copies with your application

ADULTS

- Federally Recognized CDIB and/or Tribal card
- Social Security Card
- Driver's License or State ID
- Health Insurance Cards (front and back)

MINORS

- Federally Recognized CDIB and/or Tribal Card*
- Birth Certificate
- Social Security Card
- Immunization records
- Health Insurance Cards (front and back)

**Minors may use their parent's tribal identification along with their birth certificate until their 18 birthday.*
**If the child lives with somebody other than a parent, Legal Guardianship Documents must be provided.*

CPN SPOUSE'S (Non-Native*)

- Spouse's CPN CDIB and/or Tribal Card
- Social Security Card
- Health Insurance Cards (front and back)
- Marriage License
- Driver's license or State ID

**Non-Native CPN Spouse's will be responsible for payment through their insurance and/or out of pocket.*

CPN EMPLOYEES AND THEIR DEPENDENTS COVERED BY UMR (Non-Native)

- Employee ID
- Social Security Card
- Birth Certificate (for minors)
- UMR Health Insurance Card
- Driver's license or State ID

2. Please select the services you are requesting

☐ Medical ☐ Urgent Care ☐ Behavioral Health ☐ Optometry ☐ Contract Health
☐ Dental (also requires a separate application, please contact the dental department)

3. Please choose where you would like to receive your primary medical care

☐ **CPHHS East Clinic**
2307 S. Gordon Cooper Dr.
Shawnee, OK 74801
405-273-5236

☐ **CPHHS West Clinic**
781 Grand Casino Blvd.
Shawnee, OK 74804
405-964-5770

Are you a CPN Employee? ☐ Yes ☐ No ☐ Full-time ☐ Part-time

Name _____ DOB _____

Who is your current medical provider? _____

_____ _____ _____ _____ _____
Address City State Zip Phone

When was the last time you were seen? _____

What were you seen for? _____

What Pharmacy do you currently use? _____

Do you have a specific reason/need to be seen at CPNHS? _____

All paperwork must be filled out completely and returned by mail or in person before appointments can be scheduled.

Name: Last _____ First _____ MI _____ DOB _____

PATIENT INFORMATION

Name: Last _____ First _____ Middle _____ Maiden _____

DOB _____ Birth City _____ State _____ Sex ☐ Male ☐ Female SSN _____

Primary Phone _____ Secondary _____ Work _____

Mailing Address _____ City _____ State _____ Zip _____

If an adult, Please check one: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower

Physical address *if different than mailing or if you have an APO, PO Box, or Rural Route Address, give directions to your home:*

_____

_____

Do you have Internet Access? ☐ Yes ☐ No If yes, where? (check one) ☐ Home ☐ Work ☐ Library ☐ School ☐ Phone

Would you like to be notified by email of appointment reminders, cancellations, etc.? ☐ Yes ☐ No

If yes, provide your email address _____

What is our preferred method of contact ☐ Mail ☐ Phone ☐ Text ☐ Email

What tribe are you a member of? _____

Do you have a federally Recognized Tribal ID? ☐ Yes ☐ No Certificate Degree of Indian Blood card? ☐ Yes ☐ No

Patient's Employer's Name _____ Address _____

Phone _____ ☐ Full-time ☐ Part-time

Spouse's Employer's Name _____ Address _____

Phone _____ ☐ Full-time ☐ Part-time

MINORS UNDER THE AGE OF 18

Mother's Name _____ Cell Phone _____ Other Phone _____

Mother's Employer _____ ☐ Full-time ☐ Part-time

Employer Address _____ Phone _____

Father's Name _____ Cell Phone _____ Other Phone _____

Mother's Employer _____ ☐ Full-time ☐ Part-time

Employer Address _____ Phone _____

If parents are divorced/seperated, list name of **legal** custodial parent _____

Does the child live with a step parent? ☐ Yes ☐ No If yes, list name _____

IMPORTANT

If anyone other than parents will be bringing your child for treatment, please sign a Minor Consent Form provided at registration.

Name: Last _____ First _____ MI _____ DOB _____

1. Emergency Contact/Next of Kin Information (Minors must list parent/legal guardian as next of kin)

Name _____ Phone _____ Relationship _____

Address _____ City _____ State _____ Zip _____

2. Emergency Contact Information

Name _____ Phone _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Military Service History

Are you a Veteran? ☐ Yes ☐ No If yes, what branch? ☐ Army ☐ Navy ☐ Marines ☐ AF ☐ Nat. Guard ☐ Other

Dates of service: From _____ to _____ Are you on active duty now? ☐ Yes ☐ No

Insurance Information

Do you have insurance ☐ Yes ☐ No **If yes,** please fill out the Private Insurance Worksheet provided.

Do you have Medicare ☐ Yes ☐ No **If yes,** registration will assist you in filling out a Medicare Secondary Payer Questionnaire* (MSP). In order for CPN to file with Medicare, an MSP Form must be on file and a new signature provided at every medical visit.

*Failure to provide any third-party resources (Medicare, Medicaid, Private Insurance, etc.) could result in denial of services. If a child or disabled adult does not have insurance, they will be asked to see the Benefit Coordinator and fill out a Sooner Care application and/or provide proof of income. We do not bill Native Americans for any balance after insurance but we do accept payment from insurance companies. **All the money we collect from insurers goes back into the CPN Health System and is used to improve and expand the services we provide to you and your family.**

Please be prepared to bring your insurance card on every visit and notify registration of any changes

Ethnicity, please check one ☐ Decline to answer ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown by patient

Race, please check one ☐ American Indian or Alaska Native ☐ Caucasian ☐ African American ☐ Asian
☐ Other, please specify _____

Migrant worker? ☐ Yes ☐ No

Homeless ☐ Yes ☐ No If yes, check one ☐ Homeless Shelter ☐ Transitional ☐ Doubling up ☐ Street ☐ Unknown

NOTE: Registration will ask at **every** visit if there are any changes. It is very important that we keep our records (address, phone numbers, insurance information, etc.) up to date. This not only helps us, but protects you as well.

CPN BEHAVIORAL HEALTH INSURANCE DISCLOSURE FORM

PART 1 — PATIENT INFORMATION

Patient Name _____ Chart _____

SSN _____ DOB _____ Phone _____

Primary residence address _____

Are you Native American? ☐ Yes ☐ No If yes, what tribe? _____

Do you have Medicare? ☐ Yes ☐ No If yes, what is the Medicare ID _____

Do you have Medicaid/Sooner Care? ☐ Yes ☐ No If yes, what is the Medicaid ID _____

Do you have Private insurance? ☐ Yes ☐ No Vision benefits? ☐ Yes ☐ No Dental benefits? ☐ Yes ☐ No

If you are insured, please complete Part II. If you are presently uninsured please check the appropriate box above and sign and date below.

PART II — PRIVATE INSURANCE INFORMATION

NOTE: In Part II, provide information on the **policy holder** of the patient's health insurance policy.

Name of Policy Holder _____ Relationship to Patient _____

Complete Address _____

SSN _____ DOB _____ Phone _____

Name of Insurance Company _____ Effective Date _____

Policy Holder's Employer _____ Phone _____

Policy Holder Is ☐ Full-time Employee ☐ Part-time Employee ☐ Retired/Furloughed/Laid-off

Provide information below on other family members covered by this insurance policy:

Patient's Name	Relationship to Policy Holder	Date of Birth	Chart (if known)	Effective Date

Please provide copies of your insurance cards. We will need a copy of the front and back of the card.

Please make sure your application is complete and all necessary documents are attached, then sign and date your application. Incomplete applications will be returned.

Patient Signature _____ Date _____

Parent/Guardian Signature/Relationship _____ Date _____

Note: If you or your dependents have health benefit coverage and you fail to inform us of the coverage or if you are eligible for coverage but refuse to apply, sanctions may be imposed involving suspension or withdrawal of your eligibility to receive services at the CPNRS.