Redding Rancheria Tribal Health Center

1441 Liberty Street Redding, Ca 96002

Please complete form and bring to your registration appointment. Please contact the RRTHC at 224-2700 if you need assistance completing this form.

Patient Information

Last Name | **First Name** | **Middle Initial** | **Social Security Number** ___/___/___

Address | **City** | **State** | **Zip Code** | **Date of Birth**

County | **Home Phone** | **Cell phone** | **Work Phone** | **E-mail Address**

☐ **Male** ☐ **Female** | **Marital Status** | **Maiden Name** | **Veteran** ☐ **No** ☐ **Yes**

Indian Tribe | **Tribe Code** | **Tribe Roll #** | **CA Roll #**

Fathers Name | **Place of Birth** | **Date of Birth** | **Tribe**

Mothers Name | **Place of Birth** | **Date of Birth** | **Tribe**

ALL PERSONS LIVING IN HOUSEHOLD: (Use separate sheet if needed)

Name | **Relationship:** | **Date of Birth:** | **Social Security # Number**

Name | **Relationship:** | **Date of Birth:** | **Social Security # Number**

Name | **Relationship:** | **Date of Birth:** | **Social Security # Number**

Emergency Contact

Last Name | First Name | Phone | Relationship

Responsible Party (Guarantor)

Last Name | First Name | ___/___/___ Date of Birth | Phone | Relationship

Insurance

What is the name of your insurance provider: ☐ Medicare ☐ Medicaid ☐ BC/BS ☐ Other

Other (Please Specify): _____ Effective Date: _____ / _____ / _____

Name of policy holder: Last Name | First Name | ___/___/___ Middle Initial | Relationship to Patient

Address of policy holder if not the same as Patient's

City | State | Zip Code | (_____)_____ - _____ Phone Number

Social Security Number of Policy Holder: _____ - _____ - _____

Insurance Identification Number: _____ Group Identification Number: _____

Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed Other: _____

Name of Employer (Company Name) | Occupation | Phone Number: (_____) _____ - _____

Address | City | State | Zip Code

Advance Directives

Date Reviewed: _____ ❑ None ❑ DNR ❑ Living Will ❑ Durable Power of Attorney ❑ HC Proxy

Medications

List all medications you take, prescription and nonprescription, and their dosage: ❑ No medications

Medication	Dose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Are you allergic to any medications ❑ Yes ❑ No
If yes, please list:

_____
_____
_____

Do you have any food allergies ❑ Yes ❑ No
If yes, please list:

_____
_____

Family History

Please indicate if you have any of the following in your family history by checking the box.

- ☐ Hypertension
- ☐ Coronary Artery Disease
- ☐ Diabetes Mellitus
- ☐ Cancer
- ☐ Stroke
- ☐ Thyroid
- ☐ Cholesterol

Past Medical History

Please indicate if you have ever experienced any of the following conditions by checking the appropriate box.

- ❑ Acid Reflux
- ❑ Alcohol dependence
- ❑ Anemia
- ❑ Angina
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood clots
- ❑ Broken bones
- ❑ Cancer
  Type:_____
- ❑ Chronic blood thinner use
- ❑ Chronic bronchitis
- ❑ Chronic fatigue syndrome
- ❑ Chronic hepatitis
- ❑ Chronic kidney disease
- ❑ Chronic neck pain
- ❑ Chronic sinusitis
- ❑ Crohn's disease
- ❑ Depression
- ❑ Blood transfusion
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Disc degeneration
- ❑ Duodenal ulcer
- ❑ Emphysema
- ❑ Gallbladder stones
- ❑ Gout
- ❑ Heart attack
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart rhythm
- ❑ Hypertension
- ❑ Hyperthyroidism
- ❑ Insomnia
- ❑ Kidney stones
- ❑ Liver disease
- ❑ Low blood pressure
- ❑ Migraines
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Palpatations
- ❑ Rheumatoid Arthritis
- ❑ Sciatica
- ❑ Seizures/epilepsy
- ❑ Sleep apnea
- ❑ Stomach ulcer
- ❑ Stroke (CVA)
- ❑ Thyroid disease
- ❑ Tinnitus
- ❑ Tuberculosis
- ❑ Other:

- ☐ Circulatory disease
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Irritable bowel syndrome

Surgical History

Have you had any surgeries: ☐ Yes ☐ No
If yes, please list type of surgery:

_____ _____

_____ _____

_____ _____

Social History

Do you use tobacco? ☐ Yes ☐ No ☐ Former Type of tobacco used? _____/_____
Packs per day? _____ Years smoked? _____ Year Quit? _____
Other Tobacco units per day (cans, cigars, etc)? _____
Units per day? _____ Years used?_____ Year Quit? _____

Do you drink caffeine? ☐ Yes ☐ No Type? _____ Amount Daily? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Former Year Quit? _____
Type? _____ How much per week? _____
Amount? _____ Last Drink? _____

Drugs: Do you take any 'street' drugs? ☐ Yes ☐ No Type? _____ Amount per day?_____

Immunizations

Please bring your immunization record to your first appointment.

Comments:

_____

_____

_____

For Women Only

Number of children_____ Ages _____ _____ _____ _____ _____ ____ Number of pregnancies _____

Miscarriages or abortions _____ Present method of birth control _____ Age of first period _____