Redding Rancheria
Trinity Health Center

31660 Highway 3 Weaverville CA 96093

Please complete form and bring to your registration appointment. Please contact the RRTHC at 623-0021 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
☐ Crohn's disease
☐ Depression
☐ Blood transfusion
☐ Diabetes Type I
☐ Diabetes Type II
☐ Disc degeneration
☐ Duodenal ulcer
☐ Emphysema
☐ Gallbladder stones
☐ Kidney stones
☐ Liver disease
☐ Low blood pressure
☐ Migraines
☐ Osteoarthritis
☐ Osteoporosis
☐ Palpatations
☐ Rheumatoid Arthritis
☐ Sciatica

- ☐ Cancer
  Type:________________
- ☐ Chronic blood thinner use
- ☐ Chronic bronchitis
- ☐ Chronic fatigue syndrome
- ☐ Chronic hepatitis
- ☐ Chronic kidney disease
- ☐ Chronic neck pain
- ☐ Chronic sinusitis
- ☐ Circulatory disease
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Gout
- ☐ Heart attack
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heart rhythm
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Insomnia
- ☐ Irritable bowel syndrome
- ☐ Seizures/epilepsy
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ Stroke (CVA)
- ☐ Thyroid disease
- ☐ Tinnitus
- ☐ Tuberculosis
- ☐ Other:

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 ___________