

CHART #-\_\_\_\_\_



Osage Nation  
Health Services

## ***Osage Nation Health Services New Patient Application***

***WahZhaZhe Health Center***

***715 Grandview***

***Pawhuska, OK 74056***

***918 287-9300***

**Please submit the requested documents with your completed application**

**[onhs.wzzhc@osagenation-nsn.gov](mailto:onhs.wzzhc@osagenation-nsn.gov)**

**----Incomplete applications will not be considered----**

---

- **Tribal Membership Card (Osage Members Only)**
- **Certificate Degree of Indian Blood (CDIB) or proof of Native American Descent from a federally recognized tribe of the U.S.**  
**NOTE: Children under 18 years of age, using their parent's CDIB, A state issued birth certificate will be needed.**
- **Valid Picture ID or driver's license**
- **Health Insurance Cards** *(Examples include: Blue Cross/Blue Shield, Medicare A & B, Part D-Drug Plan, Medicare Replacement/Advantage Plan, Tricare, VA health card, or any other third party coverage.)*
- **Utility Bill-** *(Examples: Gas, Water, Rent Receipt. No cut-off notices.)*

***Attention Expectant Mothers:*** Along with the above information, submit your marriage license or notarized paternity affidavit, husband/boyfriend's picture ID, proof of pregnancy like the blood serum HCG test or ultra sound, and a signed Non-Beneficiary Acknowledgement form.

***As part of this registration, a Patient Benefits Coordinators will screen those patients who do not have insurance or any kind of third party coverage***



CHART #-

**WahZhaZhe Health Center**  
**New Patient Application**  
(Please do not leave any blanks)

Legal Last Name First Name Full Middle Name

Date of Birth Social Security # Gender

List other names and aliases used (if any):

Tribal Membership or Descendancy: Blood Quantum:

Please list other Tribe(s): Blood Quantum:

Marital status: Single ☐ Married ☐ Widow/er ☐ Divorced ☐ Separated ☐

Birthplace of Patient: (City and State) Religious Preference: (Optional)

MAILING ADDRESS:

PHYSICAL ADDRESS:

PO Boxes:

City & State:

Zip Code:

Primary Phone #:

Alternate Phone #:

Work #:

Cell Phone #:

Would you be interested in communicating via text?  
☐ Yes ☐ No

Patient's FATHER:

LAST NAME, FIRST NAME, and BIRTHPLACE (City and State)

Patient's MOTHER:

MAIDEN NAME, FIRST NAME, and BIRTHPLACE (City and State)

Company Name:

Address:

City, State, Zip Code:

Phone:

Full Time: ☐ Part Time: ☐ Self Employed: ☐ Full Time: ☐ Part Time: ☐ Self Employed: ☐

\*\*\*\* For Children under 18, please list the parents' or legal guardians' employers \*\*\*\*

Do you have Internet access? Yes ☐ No ☐ E-mail address:

Internet access locations: (Check all that apply): Home ☐ Work ☐ Cell ☐ School ☐ Library ☐ other ☐

Do we have permission to send generic health information to your E-mail address? Yes ☐ No ☐

What is your preferred method to receive appointment reminders? (Check one): Phone ☐ E-mail ☐ Cell ☐ Letter ☐

What is your primary language of communication? English ☐ Tribal Language ☐ Spanish ☐

Sign Language ☐ If other than English, would you need an interpreter? Yes ☐ No ☐



CHART #-\_\_\_\_\_

Name of Emergency Contact: _____	Name of Next of Kin: _____
Phone: _____	Phone: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City & State: _____	City & State: _____
Zip Code: _____	Zip Code: _____

### MILITARY SERVICE INFORMATION

Branch of Service: _____	Vietnam Service indicated? Yes _____ No _____
Entry Date: _____	Connected? Yes _____ No _____
Separation Date: _____	Number: _____
Do you have a valid VA card? Yes _____ No _____	

Brief description of VA disability: \_\_\_\_\_

### ADVANCE DIRECTIVE/LIVING WILL

(For our patients who are 18 years or older)

Do you have an Advance Directive (Living Will) in place? YES \_\_\_\_\_ NO \_\_\_\_\_

If you answered NO, would you like some information on the subject? YES \_\_\_\_\_ NO \_\_\_\_\_

Please tell patient registration, your physician or nurse if you would like to know more about the Advance Directive (Living Will), and they will arrange for the Patient Benefits Coordinator to meet with you and answer your questions.

### INSURANCE COVERAGE

If you answer YES to any of the following, please show card/cards to Patient Registration clerk

Private Insurance: YES _____ NO _____	Medicare A and/or B: YES _____ NO _____
Affordable Care Act: YES _____ NO _____	Medicare Replacement/Advantage: YES _____ NO _____
Oklahoma SoonerCare: YES _____ NO _____	Part D (Rx Plan): YES _____ NO _____

The WahZhaZhe Health Center may disclose all or any part of the patient's record to any person or corporation which is or may be liable under contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charges, including but not limited to: hospital or medical service companies, workmen's compensation carriers, welfare funds or the patient's employer. The information authorized for release may include information which may be considered a communicable or venereal disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea and the Human Immune Deficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

I hereby assign to the clinic such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the clinic. I understand that this assignment applies only to medical services and supplies furnished to me during the time period indicated below.

By signing below, **I AUTHORIZE PAYMENT OF SUCH BENEFITS DIRECTLY TO WHA-ZHA-ZHI HEALTH CENTER.**

Patient Signature here \_\_\_\_\_

Date \_\_\_\_\_

Parent/Legal Guardian or Proxy signature here on behalf of the patient \_\_\_\_\_

Date \_\_\_\_\_



CHART #-\_\_\_\_\_

**Notice of Privacy Practices for HIPAA**  
*(Health Insurance Portability and Accountability Act)*  
*Privacy Rule*

*I hereby acknowledge receipt of the WahZhaZhe Notice of Privacy Practices at:*

WahZhaZhe Health Center  
715 Grandview  
Pawhuska, OK 74056

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Legal Guardian or Patient Representative  
(State Relationship to Patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature & title of Business Office/Patient Registrar

\_\_\_\_\_  
Date

-----  
**For patients unable to acknowledge receipt**

*I hereby certify that the patient was unable to acknowledge receipt of the WZZHC  
Notice of Privacy Practices because of reason stated below:*

\_\_\_\_\_

\_\_\_\_\_  
Signature & title of Business Office employee

\_\_\_\_\_  
Date

-----  
**For Office use only:**

Patient Name	Chart Number



CHART #- \_\_\_\_\_

**ASSIGNMENT OF BENEFITS  
AND  
AUTHORIZATION TO FURNISH INFORMATION**

**WahZhaZhe Health Center  
715 Grandview  
Pawhuska, OK 74056**

The WahZhaZhe Health Center may disclose all or any part of the patient's record to any person or corporation which is or may be liable under contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charges, including but not limited to: hospital or medical service companies, workmen's compensation carriers, welfare funds or the patient's employer.

The information authorized for release may include information which may be considered a communicable or venereal disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immune deficiency virus, also known as acquired immune deficiency syndrome (AIDS).

***I hereby assign to the WahZhaZhe Health Center such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the WahZhaZhe Health Center. I understand that this assignment applies only to medical services and supplies furnished to me during the time period indicated below.***

***I AUTHORIZE PAYMENT OF SUCH BENEFITS DIRECTLY  
TO WahZhaZhe Health Center.***

Patient or Proxy Signature: \_\_\_\_\_  
(IF OTHER THAN PATIENT SIGNATURE, PLEASE SPECIFY RELATIONSHIP TO PATIENT)

Date(s) of Service: \_\_\_\_\_

---

---

**For Office Use Only:**

Patient Name	Chart Number



CHART #-\_\_\_\_\_

**WahZhaZhe Health Center  
715 Grandview  
Pawhuska, OK 74056**

**PRIVATE INSURANCE  
POLICY HOLDER INFORMATION**

Private Insurance: ☐ YES ☐ NO

AFFORDABLE CARE ACT INSURANCE: ☐ YES ☐ NO

Policy Holder NAME: \_\_\_\_\_  
*Last First Middle*

Policy Holder's DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
*City, State Zip Code*

Phone Number: \_\_\_\_\_

**EMPLOYER INFORMATION FOR POLICY HOLDER**

Name of Employer: \_\_\_\_\_  
☐ Full Time ☐ Part Time ☐ Self Employed

Employer's Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Employer's Phone  
Number: \_\_\_\_\_

**Please list by DOB or CHART NUMBER of any covered family members:**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**OFFICE USE ONLY:**

NAME OF INSURANCE COMPANY: \_\_\_\_\_

CLAIMS MAILING ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

COVERAGE: MEDICAL DENTAL VISION

GROUP NAME: \_\_\_\_\_ GROUP # \_\_\_\_\_

POS BIN#: \_\_\_\_\_ GROUP # \_\_\_\_\_



CHART #- \_\_\_\_\_

**WahZhaZhe Health Center**  
**715 Grandview**  
**Pawhuska, OK 74056**

PRIVACY OF CONSENT  
AUTHORIZATION OF MINORS

I/We the undersigned, parent, or legal guardians of the following minor(s):

- |          |                         |
|----------|-------------------------|
| 1. _____ | DATE OF<br>BIRTH: _____ |
| 2. _____ | DATE OF<br>BIRTH: _____ |
| 3. _____ | DATE OF<br>BIRTH: _____ |
| 4. _____ | DATE OF<br>BIRTH: _____ |
| 5. _____ | DATE OF<br>BIRTH: _____ |
| 6. _____ | DATE OF<br>BIRTH: _____ |

I/We authorize any x-ray examination, anesthetic, dental, mental health, medical or surgical diagnosis or treatment by any member of the medical or nursing staff at WahZhiZhe Health Center that may be rendered to said minor under the general, specific, or special consent of

- |          |                     |
|----------|---------------------|
| 1. _____ | Relationship: _____ |
| 2. _____ | Relationship: _____ |
| 3. _____ | Relationship: _____ |
| 4. _____ | Relationship: _____ |

The temporary custodian of the minor(s). I/We authorize the medical or nursing staff of WahZhaZhe Health Center to call if any necessary consultation in his/her discretion.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but it is given to encourage those persons who have temporary custody of the minor(s), and nursing and /or medical staff to exercise their vest judgment as the requirements of such diagnosis, medical or dental treatment.

This consent shall remain effective at any time they have him/her in their care unless revoked in writing and delivered to the WahZhaZhe Health Records Department.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

