Houlton Band of Maliseet Indians

Health Department Patient Registration

Date:________________ HR#:_________________

Last Name: _____________________ First Name: ___________________ MI: ___ Maiden Name: _________________

Place of Birth: ___________________________ State of Birth: ________ Sex: _____ D.O.B: _____________________

Social Security #: _______________________ Current Community where you live: ____________________________

Mailing Address: _______________________ Town: _____________________ State: _______ Zip Code: ___________

Home Phone: _____________________ Work Phone: _____________________ Cell Phone: _____________________

Religion: __________________ Tribe Membership: ___________________ Other Tribe Membership: ______________

Current Employer: _______________________________________ Phone #: ______________________

Address: ________________________ Town: _______________________ State: _____ Zip Code: ______________

Spouses Employer: ____ Phone #: __________________

Address: ________________________ Town: _______________________ State: ______ Zip Code: ______________

Emergency Contact: _____________________________ Relationship: _________________ Phone #: ______________

Address: _____________________________ Town: ______________________ State: ______ Zip Code: ___________

Father's Last Name: _________________________ First: ______________________ Middle: ____________________

Father's Place of Birth: ___________________________________ State of Birth: _______________________

Mother's Last Name: ___________________________ First: _____________________ Middle: ______________________

Mother's Maiden Name: _________________________Mother's Place of Birth: ________________ State of Birth: _______

Do you have Medicare? No _____ Yes _____ (If yes, we will need a copy of the card)

Do you have Mainecare? No _____ Yes _____ (If yes, we will need a copy of the card)

Do you have Private Insurance? No _____ Yes _____ (If yes, we will need a copy of the card)

Do you have Railroad Retirement? No _____ Yes _____

Are you known by any other names? No _____ Yes _____ (If yes, what is it?) ________________________________

Are you a Veteran? No _____ Yes _____ Service Branch: _______________________________

Service Entry Date: _______________ Service Separation Date: ________________ Claim #: ____________________

Vietnam Service Indicated: _______________________Service Connected: _________________________

After reviewing your application for Purchased & Referred Care (formerly Contract Health Services) through the Maliseet Health & Wellness Center, we found that we cannot verify your acceptance for services until you provide us a copy of the following:

_______ Tribal 30 Day Residency Form

_______ Birth Certificate (If you are an enrolled member of HBMI the Tribal Enrollment Clerk may have your original birth certificate on file. You can request her to send us a copy.)

_______ Social Security Card

_______ Proof of Membership with a Federally Recognized Tribe

_______ Copy of insurance information (VA card, Medicare, Mainecare, private insurance, etc.)

_______ Denial Letter from DHHS for Mainecare

_______ U.S. Residency Verification (Maine State driver's license)

Thank you for your cooperation. If you have any questions about registration or would like to make an appointment at the clinic please contact Terri Haney at 532-4229. Questions about Purchased & Referred Care (PRC) please contact Beth Aucoin at 532-2240 ext. 110. Once we have received the necessary information to complete your record, we will then determine if you are eligible for Purchased & Referred Care and Direct Services.