RIVERSIDE – SAN BERNARDINO COUNTY
INDIAN HEALTH, INC.
REGISTRATION UPDATE FORM

Last Name	First Name	Date of Birth	MR# Clinic Use Only

Current Street Address	City	State	Zip	Marital Status (check one) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower
Mailing Address	City	State	Zip	Email Address

Primary Phone Number	Secondary Phone Number	Generic Health Permission (Mandatory)
( ) ☐ Cell Phone ☐ Home Phone ☐ Alternate Phone	( ) ☐ Cell Phone ☐ Home Phone ☐ Alternate Phone	(gives RSBCIHI permission to contact you for appointments or send information via text messaging or to your email address) ☐ Yes ☐ No (Opt out)

Primary Language (Mandatory-Check one box)	Preferred Contact (Check one box)	Notifications (Check Boxes)
☐ English ☐ Other Languages spoken:	☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Patient Portal ☐ Other	☐ Phone Call ☐ SMS (Text) ☐ Email ☐ Voice Reminders

Family Members (in household)	Date of Birth	Relationship

Emergency Contact Name	Phone Number	Address	Relationship

Insurance Information

Primary Insurance Company Name:	Policy Number:	Subscriber Name:
Secondary Insurance Company Name:	Policy Number:	Subscriber Name:

RSBCIHI uses Indian Health Services Reporting System Our Registration Staff are required to collect the following data.

Ethnicity (Mandatory-Check one box)	Race (Mandatory)
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Answer ☐ Unknown by patient	☐ American Indian or Alaska Native ☐ Unknown By Patient ☐ Asian ☐ Black or African American ☐ White ☐ Declined to Answer ☐ Native Hawaiian or Other Pacific Islander

Form Completed By:______________________

Clinic use only Date: ____________ Initial: __________