Nimkee
Memorial Wellness Center

Saginaw Chippewa Indian Tribe of Michigan

2591 S. Leaton Rd.
Mt. Pleasant, MI 48858
Phone: 989.775.4600
Medical Fax: 989.775.4680
Dental Fax: 989.775.4957

Patient Registration Packet

Welcome to Nimkee Memorial Wellness Center (NMWC). We're glad you have chosen to register with us. Please fill out the registration forms completely to ensure we have all the necessary information to provide you with the best care possible. If you have any questions, our office is available at (989) 775 – 4670. For more information on our hours of operation, lab hours, Purchased Referred Care (PRC) information, on-call provider number, and other clinical information, please visit http://www.sagchip.org/nimkee. Thank you!

NMWC Business Office requires documentation to determine service eligibility. Patients, parents, guardians, pregnant persons, or eligible college students must submit the appropriate documentation below before services are rendered. You will be contacted once your eligibility has been determined; if you have not been notified within 24-48 business hours, please contact our office.

Eligible Service County Area(s): Isabella, Midland, Clare, Missaukee, & Arenac

1. Valid Tribal Membership Enrollment Card:

a. Saginaw Chippewa Indian Tribal enrollment ID
b. U.S federally recognized tribal enrollment ID (residing in service area) or verification letter

2. SCIT Direct Descendent:

a. Original birth certificate
b. Parent(s) SCIT Tribal enrollment ID

3. Social Security Card

4. All Insurance Card(s)

5. Two Residency Verification Documents: current physical address only

a. Driver's License;
b. State ID;
c. Voter Registration Card;
d. Lease Agreement;
e. Vehicle Title;
f. Envelope postmarked within the past 90 days. (Including enrollees 's name)

6. Newborn Children Only:

a. Hospital birth certificate
b. Parent(s) SCIT Tribal enrollment card
c. Original birth certificate once received to complete registration

7. Pregnant Person: Required in addition

a. Positive pregnancy test verification from OB/GYN

8. College Student: Required in addition

a. Official letter/official transcripts from institute verifying full-time student enrollment

1: Patient Information

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ /_____ /_____ **Social Security Number:** _____ - _____ - _____

Place of Birth: _____

Physical Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

If Minor, child's parent/guardians name: _____

Legal Sex (for billing): ☐ Female ☐ Male

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Other

Preferred Name/Pronouns: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic or Latin

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ American Indian/Alaska Native
☐ Native Hawaiian/other Pacific Islander
☐ Black/African American
☐ White/Caucasian
☐ Asian
☐ Unknown

Preferred Language: ☐ English
☐ Spanish
☐ Other: _____

Interpreter Needed: ☐ Yes ☐ No

Do you have an Advanced Directive? ☐ Yes ☐ No

2: Tribal Affiliation

Tribe of Membership: _____

Tribal Enrollment Number: _____ **State where Enrolled:** _____

3: U.S. Veteran Status

Are you a U.S Veteran? ☐ Yes ☐ No

Service Entry Date: _____ **Service Separation Date:** _____

Vietnam Service: _____

4: Employment Status

Are you employed? ☐ Yes ☐ No

☐ Full-time ☐ Part-time ☐ Retired ☐ Student

Occupation: _____

Employer Name: _____

5: Emergency Contact

EMERGENCY CONTACT #1

Last Name: _____ **First Name:** _____

Relationship: _____ **Phone Number:** _____ - _____ - _____

EMERGENCY CONTACT #2

Last Name: _____ **First Name:** _____

Relationship: _____ **Phone Number:** _____ - _____ - _____

6: Contact Preferences

How would you like NMWC to contact you about your appointments?: ☐ Home ☐ Cell ☐ Email

Would you like communication sent to you via email?: ☐ Yes ☐ No
(I.e., appointment reminders, updates, etc.)

Email: _____

Do you have internet access?: ☐ Yes ☐ No **What access do you have?:** ☐ Internet ☐ Mobile

7: Insurance Information

Primary Insurance

Subscriber Name: _____

Subscriber ID #: _____

SSN: _____

Date of Birth: _____

Insurance Name: _____

Insurance Phone #: _____

Effective Date: _____

Termination Date: _____

Coverage Type: ☐ Medical ☐ Pharmacy ☐ Hospital ☐ DME ☐ Dental

Additional Policy Members and Relationship:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Secondary Insurance

Subscriber Name: _____

Subscriber ID #: _____

SSN: _____

Date of Birth: _____

Insurance Name: _____

Insurance Phone #: _____

Effective Date: _____

Termination Date: _____

Coverage Type: ☐ Medical ☐ Pharmacy ☐ Hospital ☐ DME ☐ Dental

Additional Policy Members and Relationship:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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Letting your dentist know about any health issues or medications you're currently taking is a great idea. This way, they can tailor your dental treatment to fit your needs and make ensure the best possible care. So, don't hesitate to share any important information with your dentist!

Patient Health Assessment

Patient Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____ **Today's Date:** _____

Patient Phone Number: _____

Patient Email: _____

Have you been seen by another provider? ☐No ☐Yes

If yes, complete the Authorization for Use or Disclosure of Protected Health Information Form *(You must sign the authorization with a Nimkee Staff as a witness.)*

Who is your preferred provider?

- ☐ Dr. Kissoondial
- ☐ Shelley Frantz, PA-C
- ☐ Sierra Harns, DNP-BC
- ☐ Penny Thompson, FNP

Have you ever been hospitalized or had a major operation?

☐ No ☐ Yes, please specify: _____

Are you allergic to any of the following? ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Latex

List all other food, drugs, and substances to which you are allergic:

List any prescription medications you take:

Do you have any other medical concerns you would like us to know about?:

Surgical History

Surgery:	Yes	No	Comments / Details / Dates
Transfusions(s)			
Adverse Reaction to Anesthesia			
Easy Bruising Tendency			
Easy Bleeding			
AAA Repair			
Appendectomy			
Cholecystectomy (Gallbladder Removal)			
Colostomy			
Hernia Repair (Femoral/Incisional/Inguinal)			

Surgical History Continued

Surgery:	Yes	No	Comments / Details / Dates
Pancreatectomy			
Repair of Abdominal Wall			
Small Bowel Resection			
Splenectomy			
Surgical Treatment for Ulcer			
Tonsillectomy			
Previous CABG			
Lung Surgery			
Thyroid Surgery			
Orthopedic Surgery			
Implant/Metal Placement/Artificial Joint			
Other Surgery Not Listed			
Breast Reconstruction			
Cesarean Section Delivery			
Hysterectomy (Total/Partial)			
Tubal Ligation			

Self Medical History

Have you had or currently have any of the following?	Yes	No	Comments / Details / Dates
Reaction to Anesthetics			
Myocardial Infarction/Heart Attack			
Alzheimer Disease			
Sickle Cell Anemia			
Bleeds Easily			
Breast Cancer			
Ovarian Cancer			
Colon Cancer			
Other Cancer			
Coronary Artery Disease			
Diabetes Mellitus			
Glaucoma			
Hepatic Disorder(s)			
Hepatitis A Virus			
Hepatitis B Virus			
Hepatitis C Virus			
Jaundice			
HIV Infection			
Hypertension/High Blood Pressure			
Migraine Headache			
Osteoarthritis			
Osteoporosis			
Pancreatitis			
Psychiatric Disorder(s)			
Asthma			
Tuberculosis			
Epilepsy and/or Recurrent Seizures			

Self Medical History Continued

Have you had or currently have any of the following?	Yes	No	Comments / Details / Dates
Stroke Syndrome			
Drug Abuse			
Thyroid Disorder(s)			
Have you been under the care of a psychiatrist?			
Have you ever been diagnosed with a mental health condition?			
Have you ever been diagnosed with a substance use disorder?			
Other Self Medical Health History			

Social History

Substance Use:	Yes	No	Type / Amount Each Use / How Often
Alcohol Use			
Tobacco			
Previous History of Smoking			
Drug Use			
Caffeine Use			
Relational History:	**Yes**	**No**	**Comments / Details / Dates**
Married and Living with Spouse			
Divorced			
Single			
Living Conditions:	**Yes**	**No**	**Comments / Details / Dates**
Living with Parents			
Caretaker of Another Person			
Resides in ALF			
Living Alone			
Other			
Other Social:	**Yes**	**No**	**Comments / Details / Dates**
Occupation			
Retired			
Student			
Recent Travel (within the last 6 months)			

Gynecological (Women Only)

Last Pap Smear: _____
MM/DD/YYYY

Previous Pregnancies Gravida: _____
(Total Number)

Previous Pregnancies Para: _____
(Total Deliveries)

Previous Pregnancies Aborta: _____
(Total Losses, Including Miscarraiges)

Age of Menopause: _____

Hysterectomy (Total/Partial): _____

Contraception: _____

First Day of Last Menstration: _____
MM/DD/YYYY

Total Vaginal Delivery: _____

Total Cesarean Delivery: _____

Currently Breastfeading? ☐Yes ☐No

Breast Issues? ☐Yes ☐No

Any Abnormal Bleeding? ☐Yes ☐No

Family Health History

Has anyone in your immediate family had any of the following?	Mother	Father	Sister	Brother	Maternal Grandma	Maternal Grandpa	Maternal Anut	Maternal Uncle	Paternal Grandma	Paternal Grandpa	Paternal Anut	Paternal Uncle
Adverse Reaction to Anesthesia												
Alcoholism												
Drug Addiction												
Allergies												
Alzheimer's												
Anxiety Disorders												
Arthritis												
Asthma												
Bleeding Problems												
Cancer												
Breast Cancer												
Ovarian Cancer												
Large Intestine Cancer												
Depression												
Diabetes Mellitus												
Glaucoma												
Myocardial Infarction/Heart Attack												
Heart Disease												
HIV-1 Infection												
Hypertension/High Blood Pressure												
Kidney Disease												
Liver Disease												
Lung Disease												
Mental/Psychological Disorder												
Migraine Headache												
Seizure Disorder												
Sickle Cell Anemia												
Sickle Cell Trait												
Stroke Syndrome												
Thyroid Disorders												
Mental Health Conditions												
Other:												

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Consent for Detailed Voice Messages

By signing by, _____, (Patient Name) hereby consent to **Nimkee Medical Clinic** leaving detailed voice messages on my voicemail regarding appointment reminders, test results, and important updates. I understand that these messages may include sensitive information and agree to take necessary precautions to protect the confidentiality of this information.

I acknowledge that I have the right to revoke this consent at any time by contacting **Nimkee's Health Information Management Department** in writing.

I understand that leaving detailed voice messages may not be the most secure method of communication and that I should contact **Nimkee Medical Clinic** directly if I have any questions or concerns about the information provided in a voicemail.

_____

Patient/Legal Guardian Signature

_____ _____

Date **Phone Number**

Refusal of Voicemail Consent

☐ **I do not consent to receiving medical information via voicemail.**

_____

Patient/Legal Guardian Signature

This form allows you to give or refuse permission for your healthcare provider to leave messages containing medical information on your voicemail.