



NHW COMMUNITY HEALTH CENTER

PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: (First, Middle, Last)								
Date of Birth: / /		Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status:		SSN: - -	
Address: (Street Name)				Apt #:	City:		State:	Zip Code:
Family Size:		Income:		Primary/Secondary Languages:				
Employer:		Occupation:		Home Phone: () -		Cell Phone: () -		
Phone: () -		Ext:	Ethnicity/Tribe:			Email Address:		
RESPONSIBLE PARTY (for patient under 18 years):				EMERGENCY CONTACT NAME:				
SSN:				Home Phone: () -				
DOB:				Cell Phone: () -				

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
Health Plan Name:		Health Plan Name:	
Insured Name:		Insured Name:	
ID #:	Group #:	ID #:	Group #:
Telephone #:		Telephone #:	

HOW DID YOU HEAR ABOUT US?

<input type="checkbox"/> Friend <input type="checkbox"/> Brochure <input type="checkbox"/> Door hanger <input type="checkbox"/> Bus shelter ad <input type="checkbox"/> Event <input type="checkbox"/> Movie theatre ad <input type="checkbox"/> Other(s): _____
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THE PRECEDING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

TREATMENT/PAYMENT AGREEMENT FOR NATIVE HEALTH

I request the above to provide me and/or my family with medical care. I acknowledge my responsibility to pay for that care according to the fees established. Furthermore, I authorize assignments of benefits for medical/dental services to be paid to Native American Community Health Center, Inc.

Signature: _____ Date: _____

CCR: _____ Date: _____