THE SUQUAMISH TRIBE

SUQUAMISH TRIBE HEALING HOUSE

Today's date:	

PATIENT INFORMATION				
Legal name as it appears on your social security card: Last name: First: Middle:				Marital status (circle one) Single / Mar / Div / Sep / Wid
Former/Maiden name:	DOB:	Age:	Sex at birth ☐ M ☐ F	Gender ☐ M ☐ F ☐ X
SSN:	Primary phone #:			Alternate phone #:
Permission to contact me for appointment reminders: ☐ YES ☐ NO Permission to leave voice mail message on phone number(s) above: ☐ YES ☐ NO				
Physical address:				Mailing address (if different)
County:				Email:
Employer:				Occupation:

IHS ELIGIBILITY	
☐ **Tribal Enrollment #:**_____ ☐ **Enrolled Descendant of Tribal Member** ☐ **Tribal Affiliation**:_____ ☐ **Not Applicable, not Native American**	
If <18 years old Custodial parent or guardian name:_____ Phone Number:_____. Custodial parent or guardian name:_____ Phone Number:_____. Legal guardian name/agency: _____ Phone Number:_____.	
Did you retire from the Military? ☐ Yes ☐ No	Are you eligible for Tricare benefits? ☐ Yes ☐ No
Do you have any unpaid Medical Bills? ☐ Yes ☐ No	☐ Hispanic ☐ Non-hispanic

EMERGENCY CONTACT	
Name of local friend or relative:	Relationship to Member:
Phone Number:	Alternate phone number:
Release medical information to this individual: ☐ YES ☐ NO	

PREVIOUS PHYSICIAN OR PRIMARY CARE CLINIC	
Clinic name:	Physician name:

PREFERRED PHARMACY	
Pharmacy:	**City:**

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INSURANCE INFORMATION		
Do you have any other Medical Insurance? ☐ Yes ☐ No If no, have you applied for Apple Health? ☐ Yes ☐ No		Date Applied:
Are you currently employed? ☐ Yes ☐ No	If yes, are you enrolled in employer medical insurance? ☐ Yes ☐ No	**Please provide your insurance card(s).**
Do you have Medicare? ☐ Yes ☐ No If yes, are you being reimbursed for the premiums? ☐ Yes ☐ No Do you pay a premium for your Medicare? ☐ Yes ☐ No ***If you are not being reimbursed please bring your current Social Security Award letter in for reimbursement**.		If yes, Medicare ID: Part D Carrier: Part D ID#:

Primary Medical Insurance Carrier:		
ID#	Group#	Effective Date:
Subscriber's name:	DOB	☐ Self ☐ Spouse ☐ Child ☐ Other
Secondary Medical Insurance Carrier:		
ID#	Group#	Effective Date:
Subscriber's name:	DOB	☐ Self ☐ Spouse ☐ Child ☐ Other

ATTESTATION

The above information is true to the best of my knowledge.

_____.
Patient Name

_____ _____
Patient/Parent/Guardia/Legal Representative signature Date

_____. _____.
Patient, if >13 years old (applies to certain medical conditions) Date

For office use only

Input by:

Checked by:

CHS