Nooksack Tribal Health Center Patient Demographic Form

SSN#: SSN#		PATIENT INFORMATION															
Martial Status Mart	Last Name:									S	5N#:						
Address line 2:	First Name:				Preferred Name:				оов:				Sex:				
Tel#: Subscriber Date Subscriber Dat	Home Address:									Marital S	tatus:						
Email:	Address line 2:																
Race: Ethnicity: HISPANIC OR LATINO? Canguage: English	City, State, Zip:									Work 1	Tel#:						
Tribe:	Email:									Cell 1	Γel#:						
Number: Num	Race:					Ethni	city:	HISF			INO?	Lan	nguage: I	Engli	sh		
No Branch? Date of Discharge: Date of Dat	Tribe:																
Preferred Phone Method: Home	Are you a Veteran?	YE	S	NO											e;		
PREFERRED PHARMACY	HOW D	o you	J PRE	FER Y	OUR.	APPO	INTM	ENT RE	EMIN	IDER (please	e ch	eck box	es l	elow	r)	
Pharmacy Name: Pharmacy Tel#: EMPLOYER INFORMATION Name: Fhone#: Address: Suite #: City/St/Zip: EMGERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?) Name: Tel#: Relationship: PRIMARY INSURANCE Plan/Policy Name: Group #: Subscriber DOB: Subscriber Name: SECONDARY INSURANCE Plan/Policy Name: Group #: Group #: Other Plan Tel#: Subscriber DOB:	Preferred Phone Meth	od:	Home	□w	ork 🗆	Cell				Comm	unicate	by:	: Phone	e 🗆	Emai	ı 🗆	Text \square
Tel#:						PRE	FERRI	ED PHA	RMA	ACY	·				• • • • • • • • • • • • • • • • • • • •		
Pharmacy Address: EMPLOYER INFORMATION Phone#: Phone#: Phone#: Phone#: Phone#: Phone#: Phone#: Phone#: Phone#: Phone#: P	Pharmacy Name:									P							
Name: Suite #: Address: Suite #: City/St/Zip: EMGERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?) Name: Tel# Relationship: PRIMARY INSURANCE Plan/Policy Name: Group #: Subscriber DOB: Subscriber Name: Subscriber ID: Contact Insurance Plan/Policy Name: Group #: Other SECONDARY INSURANCE Plan Tel#: Subscriber DOB: Subscriber DOB: Subscriber Name: Subscriber DOB: Subscriber DOB:	Pharmacy Address:									City							
Address: Suite #: City/St/Zip: EMGERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?) Name: Tel# Relationship: PRIMARY INSURANCE Plan Tel#: Subscriber DOB: Subscriber Name: Subscriber ID: Relationship to Patient: (check box) Self Wife Husband Parent Other SECONDARY INSURANCE Plan/Policy Name: Group #: Plan Tel#: Subscriber DOB: Subscriber DOB: Subscriber DOB:																	
EMGERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?) Name: Tel# Relationship: PRIMARY INSURANCE Plan/Policy Name: Group #: Subscriber DOB: Subscriber Name: Subscriber ID: Relationship to Patient: (check box) Self Wife Husband Parent Other SECONDARY INSURANCE Plan/Policy Name: Group #: Subscriber DOB:	Name:			·		·· · · · · · · · · · · · · · · · · · ·							Phone#:				
EMGERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?) Name: Tel# Relationship: PRIMARY INSURANCE Plan/Policy Name: Group #: Subscriber DOB: Subscriber Name: Subscriber ID: Relationship to Patient: (check box) Self Wife Husband Parent Other SECONDARY INSURANCE Plan/Policy Name: Group #: Subscriber DOB: Subscriber DOB: Subscriber DOB: Subscriber DOB: Subscriber DOB: Subscriber DOB:	Address:		ı		100						Suite #	#:					
Name: Tel# Relationship: PRIMARY INSURANCE Plan/Policy Name: Group #: Plan Tel#: Subscriber DOB: Subscriber Name: Subscriber ID: Relationship to Patient: (check box) Self Wife Husband Parent Other SECONDARY INSURANCE Plan/Policy Name: Group #: Plan Tel#: Subscriber DOB: Subscriber DOB: Subscriber DOB: Subscriber DOB:	City/St/Zip:											·····		:			
PRIMARY INSURANCE Plan/Policy Name: Group #: Plan Tel#: Subscriber DOB: Subscriber Name: Subscriber ID: Relationship to Patient: (check box) Self Wife Husband Parent Other SECONDARY INSURANCE Plan/Policy Name: Group #: Plan Tel#: Subscriber DOB: Subscriber Name: Subscriber DOB: Subscriber Name: Subscriber ID:	EMGERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?)																
Plan/Policy Name: Group #: Plan Tel#: Subscriber DOB: Subscriber Name: Subscriber ID: Relationship to Patient: (check box) Self Wife Husband Parent Other SECONDARY INSURANCE Plan/Policy Name: Group #: Plan Tel#: Subscriber DOB: Subscriber Name: Subscriber ID:	Name:	<u> </u>					Tel#				Re	elati	ionship:				
Plan Tel#: Subscriber DOB: Subscriber Name: Subscriber ID: Relationship to Patient: (check box) Self Wife Husband Parent Other SECONDARY INSURANCE Plan/Policy Name: Group #: Plan Tel#: Subscriber DOB: Subscriber Name: Subscriber ID:						PRI	MARY	/ INSU	RAN	CE				·	Y		
Subscriber Name: Relationship to Patient: (check box) Self Wife Husband Parent Other SECONDARY INSURANCE Plan/Policy Name: Plan Tel#: Subscriber DOB: Subscriber ID:	Plan/Policy Name:											G	Group #:				
Relationship to Patient: (check box) Self Wife Husband Parent Other SECONDARY INSURANCE Plan/Policy Name: Group #: Plan Tel#: Subscriber DOB: Subscriber Name: Subscriber ID:	Plan Tel#:	<u> </u>									Subs	crib	er DOB:				
SECONDARY INSURANCE Plan/Policy Name: Group #: Plan Tel#: Subscriber DOB: Subscriber Name: Subscriber ID:	Subscriber Name:	I									Su	bscr	riber ID:				
Plan/Policy Name: Plan Tel#: Subscriber DOB: Subscriber ID:	Relationship to Patien	t: (ch	eck bo	ox)		Self		Wife		Husb	and		Paren	it		Oth	ner
Plan Tel#: Subscriber DOB: Subscriber ID:					. <u></u>	SECO	NDAF	RY INS	URA	NCE	,						
Subscriber Name: Subscriber ID:	Plan/Policy Name:											G	Group #:				
	Plan Tel#:	Plan Tel#:							Subscriber DOB:								
Relationship to Patient: (check box) Self Wife Husband Parent Other	Subscriber Name:										Su	bscr	riber ID:				
	Relationship to Patient	t: (ch	eck bo	x)	☐ s	elf		Wife		Husba	and		Paren	ıt		Oth	er

Patient or authorized person's signature		Date:
--	--	-------