NEW PATIENT QUESTIONNAIRE

Coquille Indian Tribe Community Health Center
600 Miluk Drive PO Box 3190
Phone: (541)888-9414 or (866)200-0744 Fax (541)888-5556
Coos Bay, OR 97420

Date:	Who Recommended CITCHC?:
Full Legal Name: *(If under 18, name of parent or guardian)*	
DOB:	Phone Number:
Email address:	
Social Security Number:	
Mailing Address:	
Previous Health Care Provider:	
Native American: ☐yes ☐no *If Native, please attach: Copy of your Tribal ID, **OR** copy of Tribal ID of parent/grandparent **and** Birth Certificate(s) linking you to the enrolled Tribal member*	
Insurance(s): Please include copy of card. If not available, include ID# here: ID#	***Uninsured American Indians/Alaska Natives will be required to provide proof of income and apply for Oregon Health Plan prior to their 1st appointment. We will assist you with the application process.**
Medical Problems/Diagnosis:	
Medications:	

OFFICIAL USE ONLY:

CITCHC Approved: ☐yes ☐no Date: _____

Signature: _____