Ko-Kwel Wellness Center

630 Miluk Drive, PO Box 3190
Coos Bay, OR 97420
Phone (541) 888-9494 or (800) 344-8583
Fax (541) 888-5556

NEW PATIENT QUESTIONNAIRE

Date:	Who Recommended KWC-Coos Bay:	
Full Legal Name: *(If under 18, ALSO include name of parent or guardian)*		
DOB:	Gender:	Phone Number(s): *Providing your Cell Phone # allows us to text you reminders.
Mailing Address:		
Social Security Number:	Email address:	
Race: (N/A if you prefer not to answer)		
Previous Health Care Provider:		
Native American: ☐ yes ☐ no *If a related to a tribe, you will be contacted by our office to provide secure copies of your Tribal ID, OR Tribal ID of parent/grandparent and Birth Certificate(s) linking you to the enrolled Tribal member*		
Insurance(s): **Our office will be in contact for copies of insurance cards.**	***Uninsured American Indians/Alaska Natives will be required to provide proof of income and apply for Oregon Health Plan prior to their first appointment. We will assist you with the application process.**	
Medical Problems/Diagnosis:		
Medications:		

OFFICIAL USE ONLY:

KWC Approved: ☐ yes ☐ no Date: _____

Signature: _____

SUBMIT