2401 River Road
Ste #101
Eugene, OR 97404
Phone: (541) 916-7025
Fax: (541) 916-7048
Email: KoKwel.Eug@coquilletribe.org

NEW PATIENT QUESTIONNAIRE

Date:	Who Recommended KWC-Eugene:		
Full Legal Name: *(If under 18, ALSO include name of parent or guardian)*			
DOB:	Gender:	Home Phone:	Cell Phone#:
		**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 you are an enrolled tribal member or a descendent of an enrolled tribal member, you will be contacted by our office to securely provide 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:
CITCHC Approved: ☐yes ☐no Date: ______________________________
Signature: ____

Additional Information

Employer: ___________________________________ Occupation: ___________________________

Address: ____Work Phone: _______________

Spouse/Parent: ______________________ DOB: _______________ Phone # ____________________

How do you intend to pay? Native American ____ Cash ____ Check ____ Insurance ____

Primary Insurance Co. __________________________ Phone _______________ Policy # ______________

Name of Policy Holder __________________________ Policy Holder's Date of Birth ______________________

*** **Our office will be in contact for copies of all insurance cards.*

Secondary Insurance Co. _______________________ Phone ________________ Policy # ______________

Name of Policy Holder ___________________________ Policy Holder's Date of Birth _______________________

*** **Our office will be in contact for copies of all insurance cards.*

If someone other than the PATIENT is responsible for payment, complete the following

Responsible party name_______________________________ Relation to patient_____________________

Address: ____ Phone _______________________________

SS#__________________________ Date of Birth ______________ Email_____________________

In Case of EMERGENCY:

Person to contact (other than spouse) ___________________________ Phone __________________

Step One: Download and complete the form and save it to your desktop.
Step Two: Attach and Email this form to KoKwel.Eug@coquilletribe.org
Or, mail the completed form to the address listed at the top of the page.