Nooksack Tribal Health Center
Patient Demographic Form

PATIENT INFORMATION							
Last Name:				SSN#:			
First Name:		Preferred Name:		DOB:		Sex:	
Home Address:				Marital Status:			
Address line 2:				Home Tel#:			
City, State, Zip:				Work Tel#:			
Email:				Cell Tel#:			
Race:		Ethnicity:	HISPANIC OR LATINO? Y OR N		Language: English		
Tribe:		Enrollment number:					
Are you a Veteran?	YES NO	What Branch?			Date of Entry: Date of Discharge:		

HOW DO YOU PREFER YOUR APPOINTMENT REMINDER (please check boxes below)			
Preferred Phone Method:	Home ☐ Work ☐ Cell ☐	Communicate by:	Phone ☐ Email ☐ Text ☐

PREFERRED PHARMACY			
Pharmacy Name:		Pharmacy Tel#:	
Pharmacy Address:		City/St/Zip:	

EMPLOYER INFORMATION			
Name:		Phone#:	
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 #:	
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:	
Relationship to Patient: (check box)	☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other		

Patient or authorized person's signature: _____ **Date:** _____