Ko-Kwel Wellness Center

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*			
Are you a Veteran? ☐yes ☐no			
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:
CIT KWC 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 _____

Email this form to: KoKwel.Eug@coquilletribe.org
Or, Mail to the address listed at the top of page 1.