Ko-Kwel Wellness Center

Dear Patient and family,

Thank you for your interest in the Ko-Kwel Wellness Centers located in Coos Bay and Eugene, Oregon. Attached to this letter is the New Patient Enrollment Packet which includes the required forms to help us enroll you in our practice and manage your care.

Please complete and return ALL forms:

Please make sure to follow all instructions on these forms, as well as initial and sign (16 & older must sign - under 16 parent or guardian can sign for patient). If this step is missed it can hold up being scheduled.

If applicable, we also need proof of tribal affiliation or Alaska Native. This may be your tribal ID document, or it could be the tribal ID of your parent or grandparent, along with birth certificates linking you to the enrolled tribal member. Please include photocopies of these documents with your enrollment packet.

To submit your forms:
IN-PERSON: Drop the completed forms to your applicable clinic.
EMAIL: Email the completed forms to the email address listed below for the applicable clinic. If you email your forms, remove the social security number (SSN) and date of birth. We will call you for this information.
U.S. MAIL: Complete all forms and mail to the address listed below for the applicable clinic.
FAX: Complete all forms and fax to the fax number listed below for the applicable clinic.

Coos Bay		Eugene	
Email:	KWC.business@coquilletribe.org	Email:	Email: kokwel.eug@coquilletribe.org
Fax:	541-888-4435	Fax:	Fax: 541-916-7048
Address:	630 Miluk Drive Coos Bay, OR 97420	Address:	2401 River Road, Ste 101 Eugene, OR 97420
Phone:	541-888-9494	Phone:	541-916-7025

IMPORTANT- PLEASE READ

It may take up to 14-30 days for processing of enrollment for primary care and/or behavioral health. This allows for records from previous provider(s) to be requested and reviewed. A member of our team will contact you once we are able to schedule your visit.

For more information, contact the Ko-Kwel Wellness Center Medical or Dental Staff at 541-888-9494. Choose option 1 for Medical or option 6 for Dental.

Mind ▲ Body ▲ Spirit ▲ Community

Ko-Kwel Wellness Center

NEW PATIENT ENROLLMENT

☐ **Primary Care Coos Bay** ☐ **Primary Care Eugene** ☐ **Behavioral Health** ☐ **Coos Bay Dental**

Last Name:	First Name:	Middle Initial:
Date of Birth:	If under 18 years of age, name of parent or legal guardian:	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other		
SSN:	Driver's License Number:	
Preferred Phone:	Email Address:	
Alternate phone:	Do you consent to receive text reminders from us? ☐ Yes ☐ No	
Physical Address:		
Mailing address:		

Gender Assigned at Birth: ☐ Male ☐ Female	Gender Identity:	Preferred Pronouns:
Race/Ethnicity: Why do we ask? Race/ethnicity can be attributed to higher incidents of certain medical conditions. This data can assist your healthcare team in determining screening needs.		
☐ Hispanic/Latino ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other ☐ Prefer Not to Answer		
Native American: ☐ Yes ☐ No	Alaska Native: ☐ Yes ☐ No	If yes, tell us your tribe:
Are you a Veteran: ☐ Yes ☐ No		

Emergency Contact

To allow KWC staff members to communicate with your emergency contact, please complete, sign, and submit the *Authorization to Discuss Medical Information* form within the welcome packet or access the form on the KWC website at https://kokwelwellness.org/.

Name:	Phone:
Relationship:	Address (if known):

Preferred Pharmacy

Pharmacy Name:	
Pharmacy Address:	Pharmacy Phone Number:

Insurance and Billing

** If you are Native American or Alaska Native and are currently uninsured, KWC can assist you with your application for the Oregon Health Plan. Visit https://www.oregon.gov/oha/HSD/OHP/Pages/Apply.aspx to find out more. Contact us to start the process prior to your first appointment.

Responsible Party	
Name of Person Responsible for Payment:	Relationship to patient:
SSN:	DOB:
Address:	
Phone Number:	Email:

Medical Insurance Information ** Bring your insurance card with you to your first appointment and whenever your insurance changes.	
Primary Insurance	
Primary Insurance Carrier:	Insurance Phone:
Name of Policy Holder:	Policy Holder Date of Birth:
Relationship to Policy Holder:	Billing Address:
Policy Number:	Group Policy Number:
Secondary Insurance, if applicable	
Secondary Insurance Carrier:	Insurance Phone:
Name of Policy Holder:	Policy Holder Date of Birth:
Relationship to Policy Holder:	Billing Address:
Policy Number:	Group Policy Number:

Official Use Only
KWC Approved: ☐ Yes ☐ No
Date: _____
Signature: _____