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 97404
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: _____

Ko-Kwel Wellness Center

Authorization to Disclose and/or Obtain Health and Dental Records

Patient Name: _____
First Middle Last

Date of Birth: _____ SSN:_____

By signing below, I authorize

☐ Ko-Kwel Wellness Center Coos Bay
630 Miluk Drive
Coos Bay, Oregon 97420
Fax: 541-888-5556

☐ Ko-Kwel Wellness Center Eugene
2401 River Road, Ste 101
Eugene, Oregon 97404
Fax: 541-916-7049

☐ To DISCLOSE my health information to:
☐ To OBTAIN my health information from:

Facility and/or Entity Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

The purpose of this release is:

☐ Continuing Medical Care
☐ Personal
☐ Other: _____

The information to be disclosed is:

☐ Entire Record
☐ Specified time period: _____
☐ Other (specify): _____

By initialing the spaces below, I authorize release of the following information:

_____ HIV/AIDS Related information

_____ Mental Health Information

_____ Genetic Testing Information

_____ Drug/Alcohol Diagnosis, Treatment or Referral Information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage.

Unless revoked, this authorization expires _____ or within one year of signature.

Signature of Patient: _____ Date: _____

_____ Date: _____
Signature of Authorized Representative (state relationship to patient)

Ko-Kwel
Wellness Center

New Patient Intake Form

Today's Date: _____

** Please make sure this packet is complete and filled out correctly, as it may delay scheduling an appointment with a provider**

Patient Name: _____ DOB: _____

Previous Physician: _____

Why are you leaving your previous physician? _____

_____

Urgent/ Acute medical problem: _____

_____

Medication Allergies:

	Allergy	**Reaction**
1.	_____	
2.	_____	
3.	_____	
4.	_____	

Current Medications: (Name, Dose, Frequency) Include over the counter and herbal remedies:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

** Please bring all of your medications to your initial visit

Past Medical History

		Date of Onset			Date of Onset
	Allergies			Heart Disease	
	Anemia			High Blood Pressure	
	Angina			High Cholesterol	
	Anxiety			Irregular or Rapid Heart Rate	
	Arthritis			Irregular Heart	
	Asthma			Irritable Bowel	
	Benign Prostatic Hypertrophy			Liver Disease	
	Blood Clots			Migraines	
	COPD			Myocardial Infarct	
	Coronary Artery Disease			Osteoporosis	
	Cancer			Kidney Disease	
	Depression			Seizure Disorder	
	Diabetes Type 1			Stroke	
	Diabetes Type 2			Thyroid Disease	
	GERD/Reflux			Irritable Bowel Disease	
	Gallbladder Disease				

Other Medical Problems:

_____ _____

_____ _____

_____ _____

Past Surgical History

		Date			Date
	Angioplasty			Hernia Repair	
	Appendectomy			Hip Replacement	
	Arthroscopic Knee			Knee Replacement	
	Blood Transfusion			Surgical Repair of Broken Bone	
	Carpal Tunnel Release			Pacemaker	
	Cataract Removal			Removal of all or partial Colon	
	Back Surgery			Thyroid Removal	
	Coronary Artery Bypass Graft			Tonsil Removal	
	Gallbladder Removal			Colostomy	
	Gastric Bypass				

Other Surgeries:

_____ _____

_____ _____

_____ _____

Have you ever had a colonoscopy? ☐ Yes ☐ No

If yes, when? _____

If female, have you ever had a mammogram? ☐ Yes ☐ No

If yes, when? _____

If female, have you ever had a Pap? ☐ Yes ☐ No

If yes, when? _____

Family History

☐ **Adopted- no family history known**

Check if the indicated family member has any of the following. Also indicate if it were the cause of death (COD)

	Mother	Father	Brother(s)	Sister(s)		
Alive and Well (age)						
Deceased						
ADD/ADHD						
Alcoholism						
Allergies						
Alzheimer's Disease						
Arthritis						
Asthma						
Coronary Artery Disease						
Cancer:						
Type						
CVA (Stroke)						
Depression						
Developmental delay						
Diabetes						
Eczema						
Genetic Disease						
Type						
Hearing Deficiency						
High blood pressure						
High Cholesterol						
Irritable Bowel Syndrome						
Learning Disability						
Mental Illness						
Migraines						
Obesity						
Osteoporosis						
Peripheral Vascular Disease						
Renal Disease						
Thyroid Disorder						
Other:						

Smoking History:

Have you ever used tobacco? ☐ Yes ☐ No/ Never ☐ Unknown

Please check any of the below that you have ever used:

		Amount per day	Number of Years	Age Started	Age Stopped
	Cigarettes				
	Cigarillos				
	Cigar				
	Pipe				
	Chew				
	Snuff				
	Vape/E-cigarettes				

If Yes, have you ever tried to quit? ☐ Yes ☐ No

Is there secondhand smoke exposure? ☐ Yes ☐ No

Alcohol History

Do you drink Alcohol? ☐ Yes ☐ No ☐ Previously (date quit) _____

If yes, frequency? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Last Drink: ☐ Today ☐ Yesterday ☐ 2 weeks ago ☐ A Year Ago ☐ Other: _____

Caffeine History

Do you drink Caffeine? ☐ Yes ☐ No

If yes, type: ☐ Chocolate ☐ Energy Drinks ☐ Tablets ☐ Coffee ☐ Tea ☐ Soda ☐ Other

Amount of Caffeine per day _____ ☐ Ounces ☐ Cups

Lifestyle

Hand Dominance ☐ Left ☐ Right ☐ Ambidextrous

Do you or have you served in the Military? ☐ Yes ☐ No

Do you use a seatbelt? ☐ Yes ☐ No

Have you traveled out of the state recently? ☐ Yes ☐ No

Have you traveled out of the country recently? ☐ Yes ☐ No

Do you have firearms in your home? ☐ Yes ☐ No

Do you agree to receive blood/blood products? ☐ Yes ☐ No

What is your activity level? ☐ Sedentary ☐ Moderate ☐ Vigorous

Have you had any falls in the past year? ☐ Yes ☐ No

If yes, how many? _____

Did the fall(s) result in injury? ☐ Yes ☐ No