K'ima:w Medical Center

An Entity of the Hoopa Valley Tribe

Family Information Cont'd:

Mother's Maiden Name:_____ City/State of Birth:_____

Mother's Employer and Address:_____

Mother's Phone: ( ) _____ - _____

Spouse's Employer and Address: _____

Number in Household:_____ Total Household Income: _____ Household Income Period: _____

Next of Kin:

Last Name:_____ First Name: _____ Relationship:_____

Address:_____ City: _____ State:_____ Zip Code:_____

Phone Number: ( ) _____ - _____ Work Phone: ( ) _____ - _____

Veterans Information: Are you a Veteran? YES / NO (If Yes, please continue)

Service Branch: _____Service Entry Date:_____ Service Separation Date: _____

Vietnam Service? YES / NO Services Connected? YES / NO

Description of VA Disability: _____

Are you a Migrant Worker? YES / NO Are you Homeless? YES / NO

Insurance Information:

Do you currently have insurance coverage? YES—Please circle and provide cards NO

Blue Cross Blue Shield Partnership Medi-Cal Medicare Railroad Retirement TRICARE

Other:_____

By signing, I certify that the foregoing information is true and correct.

_____ _____

Patient Signature Date

Please sign below if the patient is a minor: I attest that I am the legal guardian of said patient.

_____ _____ _____

Parent or Legal Guardian Signature Relationship Date

K'ima:w Employee Signature: _____ Date: _____