PATIENT INFORMATION SHEET Date:_ _ _ _ _ _ _ _ _

Name: (Last, First, Middle}	Other Names used	Chart No.	Sex:

Birth Date:	Place of Birth (City, State)	Social Security No:	Marital St atus:
Mailing Address:		City, State:	Zip Code:
Current Community: (County)		Do you have an Advance Directive? LJ Yes ONo	
Primary Phone Number:		Other Phone Number:	
Race:		Ethnicity:	

Indian Blood Quantum:	List all Tribes:	Tribe Quantum:
		Tribe Quantum:

Father's Name:	Place of Birth: (City, State):	Phone Number:
Mother's Maiden Name:	Place of Birth: (City, State):	Phone Number:
Mother's Employer (if Minor)	Father's Employer (if minor)	
Spouse's Employer:	Spouse Employer Address	Spouse emp. Phone:
Employer:	Employer Address:	Employer Phone:
Emergency Contact Person (Relationship)	Emergency Contact Address:	Phone Number:
Next of Kin Person (Relationship)	Next of Kin Address:	Phone Number:

Military Service: O ves [_j No	Branch:	Vietnam Veteran: Oves ONo	Entry Date:	Separation Date:	Service Connected: OvesONo
Primary Language:	Other:	Interpreter: Oves ONo	Internet Access: Oves ONo	If yes, Where?	

Email Address:	D Phone LJ How do you like to receive information: Emai l 0 Mail

Do you have Medicare? LJ Ves LJ No Medicare Number: _____	Medicaid: O ves D No Medicaid Number: _____	Private Insurance ID# Oself D Family O Dental