NEW PATIENT QUESTIONNAIRE

Coquille Indian Tribe Community Health Center
600 Miluk Drive PO Box 3190
Phone: (541)888-9414 or (866)200-0744 Fax (541)888-5556
Coos Bay, OR 97420

Date:	Who Recommended CITCHC:
Full Legal Name:	
DOB: Phone Number: (Home) (Work) Social Security Number:	
Mailing Address:	
Reason for Appointment:	
Previous Provider:	
Native American: ☐yes ☐no *If Native, please attach: Copy of your Tribal ID, **OR** copy of Tribal ID of parent/grandparent **and** Birth Certificate(s) linking you to the enrolled Tribal member*	
Insurance(s):	ID#:
Medical Problems/Diagnosis:	
Medications:	

OFFICIAL USE ONLY:
CITCHC Approved: ☐yes ☐no Date: _____ Signature: _____