YELLOWHAWK
TRIBAL HEALTH CENTER

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OFFICE USE ONLY

Eligibility: PRC _______ Direct ____ Chart #________________

Authorizing Official Initials: ______Date Authorized: ____/___/___

P.O. Box 160
46314 Timíne Way
Pendleton, OR 97801
Phone: (541) 966-9830
Fax: (541) 240-8760
Website: www.yellowhawk.org

PATIENT UPDATE FORM

PLEASE FILL IN ALL SPACES, AND SIGN AND DATE THE BOTTOM OF THE FORM TO HAVE A COMPLETED FORM

Legal Name (First): ___________________________________Last: ______________________________________

Date of Birth (mm/dd/yyyy): _____/_____/_____ Social Security #: _______-_____-_______Male ☐ Female ☐

Marital Status (check one): Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated ☐

Physical Address: _______________________________________ City_____________________State_____Zip ________

Date moved to the above address: _____/_____/_____**

Mailing Address (if different):____City___________ State _____Zip ______

Phone Numbers: Cell: (____)____-_______ Home: (____)____-_______ Cell/Msg (other): (____)____-_________

E-mail Address: ____________________________@______________ U.S. Veteran - Yes☐ No☐ Veteran # ________

Employer :____ Work Ph#: (____)____-_______

Emergency Contact Name: _____________________________________ Relationship: ____________________________

Emergency Contact Address: ____Ph # (____)____-_______

INSURANCE INFORMATION

Ins Company Name	Subscriber Name	Employer Name	Subscriber Birthdate	Subscriber Address	Policy/ID Number	Group Number

Children or Spouse Living With You: (Please check appropriate box after entering names)

Name	Husband?	Wife?	Son?	Daughter?	Niece?	Nephew?	Nephew?	Grandchild?

- I request payment of authorized benefits be made on my behalf to Yellowhawk Tribal Health Center for services furnished to me by Yellowhawk providers.
- I authorize Yellowhawk Tribal health Center and Yellowhawk Providers to release any medical information necessary for diagnosis and further treatment, or other information to process this claim. I permit a copy of this authorization to be used in place of the original.

X____ ____

Signature of Patient, Guardian or Responsible Party Date Signed