MRN:

Lower Elwha Health Department

243511 Highway 101 West,
Port Angeles,WA 98363
Phone: *360.452.6252* ***Fax:*** *360.452.6274*

PAO 21 Form

Today's Date:	Who is your PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital Status:
Preferred name:		Pronoun:	

Is this your legal name? [ ] yes [ ] no	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:

Mailing Address: City:	State:	Zip:
Physical Address: [ ] (Check box if same as above) City:	State:	Zip:

Social Security no.:	Primary phone no.:	Secondary phone no.:
Occupation:	Employer:	Employer phone no:
Do you have internet access? [ ] yes [ ] no	Email address:	Preferred method of communication? [ ]PHONE [ ]MAIL [ ]DO NOT CONTACT

AMERICAN INDIAN / ALASKA NATIVE INFORMATION

Religious Preference:	Tribe of Membership:	Tribal Enrollment Number:
Tribal Blood Quantum:	Other Tribe and Blood Quantum:	Which parent is descendancy through: [ ] Mother [ ] Father

IN CASE OF EMERGENCY

Emergency contact:	DOB:
Relationship to patient:	Home phone no:
Name of relative (Next of Kin):	
Relationship to patient:	Home Phone no:

BILLING INFORMATION

(Please give insurance card to the receptionist)		
Check here if person responsible for bill is patient [ ] **Please proceed to INSURANCE INFORMATION on page 2**		
Person responsible for bill (if different from patient):		
Birth date:	Address:	Home phone:

Is this person a patient here: [ ] yes [ ] no	Is this patient covered by insurance: [ ] yes [ ] no

Occupation:		Employer:	Employer address:	Employer phone no.:

INSURANCE INFORMATION

Please indicate primary insurance:		
Subscriber's name:	Subscriber's S.S. no.:	Birth date:
Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:		
Name of secondary insurance (if applicable):		
Subscriber's name: [ ] same as above	Subscriber's S.S. no.: [ ] same as above	Birth date: [ ] same as above
Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:		

OTHER PATIENT DATA

Ethnicity: [ ] Decline to specify [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Other [ ] Unknown	Race:	Primary language:	Other language spoken:

Are you a migrant worker? [ ] yes [ ] no	Are you currently homeless? [ ] yes [ ] no
Are you a Veteran? [ ] yes [ ] no	Mother's maiden name:

OPTIONAL HOUSEHOLD INFORMATION FOR INSURANCE ELIGIBILITY PURPOSES

How many people are in your household?	What's your household income?

HIPPA AND ASSIGNMENT OF BENEFITS

I acknowledge I received the IHS notice of Privacy Practices

Signature: ____________________________________ Date: ___________

I hereby give the Lower Elwha Health Department permission to leave messages for me regarding lab results, appointments, or procedures. I also acknowledge that it is my responsibility to provide a current phone number. You may contact me by:

[ ] Voicemail/ Answering Machine

[ ] Spouse/significant other or family member who is to have access to my health information

________________________________(name/phone number)

[ ] Leaving messages with the individuals named below:

____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the Lower Elwha Health Department or insurance company to release any information required to process my claims.

Patient/Guardian signature   Date

FOR OFFICE USE ONLY

[ ] Ineligible   [ ]Direct Care Only   [ ] CHS/PRC Eligible