

Oklahoma City Indian Clinic, Patient Registration Form

(Please use **BLACK INK** only)

Chart Number _____

PATIENT INFORMATION

Last Name First Middle Maiden

MALE / FEMALE
(Circle One) _____
Date of Birth City and State of Birth Other Names Used

_____/_____/_____
Social Security Number Marital Status: M / S / D / W
(Circle One) _____
Tribe Blood Degree

Mailing Address City State Zip

(_____) _____ (_____) _____ (_____) _____
Home Phone Number Cell Phone Number Contact Number

Do you have Internet access? YES NO If YES, Where? HOME WORK OTHER _____

Email Address: _____

EMPLOYMENT

Are you employed or is your parent employed? Full-time Part-time Retired Unemployed Active Military

Employer Name Address City State Zip Phone Number

Spouse or mother/father employed?

Employer Name Address City State Zip Phone Number

Are you a Veteran? YES NO Branch: _____ Date of Discharge: _____

FAMILY INFORMATION

Father's Name City and State of Birth Mother's Name (Maiden) City and State of Birth

EMERGENCY & NEXT OF KIN CONTACT NUMBERS (List two **different** contact numbers outside the home.)

Emergency Contact Name Relationship Address City State Zip Phone Number

Next of Kin Contact Name Relationship Address City State Zip Phone Number

INSURANCE INFORMATION

Do you have Medicare? YES NO Medicare Number _____

Do you have Medicaid/SoonerCare? YES NO Medicaid Number _____

Do you have Private or Group Insurance? YES NO Do you have Secondary coverage? YES NO

