The following information is requested in order to establish a medical chart at San Carlos Apache Healthcare Center.

Last Name/ First/ Middle:			CHART #
Date of Birth:	Sex: (Circle One) Male Female		Social Security #
Religion:			Birthplace (City/State)
Tribe (If Applicable:	Degree of Indian Blood – Indian Agency Registered(phone/address)		
Current Mailing Address: (PO BOX #,City,State,Zip)			PHONE #
Physical Address (Where you live)			Community: (Circle One) 7-mile Gilson Wash Bylas Peridot
IF UNDER 18			
Fathers Name (Last/First)	Tribe/Degree of Indian Blood		Fathers Birthplace (City/State)
Is the Father working? Yes or No	Employer Name:		Fathers Income: Hourly/Weekly or Annual
Mothers Name (Last/First)	Tribe/Degree of Indian Blood		Mothers Birthplace (City/State)
Is the Mother working? Yes or No	Employer Name:		Mothers Income: Hourly/Weekly or Annual
Other Information			
Emergency Contact Name:	Mailing Address:	Phone #	Relationship:
Next of Kin Name:	Mailing Address:	Phone #	Relationship:
Patient Employer (Company Name, Address, Phone Number)			
Spouse Employer (Company Name, Address, Phone Number)			
Are you a student? If yes, where?		Date Patient Arrived in San Carlos (month/year)	
Company Name:	Policy/Group Number:	Date of Eligibility:	

( ) MEDICARE: _____

( ) AHCCCS: _____

( ) OTHER INSURANCE: _____

Veterans Status: Serial Number: Dates:

Service Connection:

I Certify the Information is true to the Best of my Knowledge.

_____ _____

Patient Signature or Parent Signature of Minor Date

_____ _____

Patient Registration Clerk Signature Date