

**N.E. WASHINGTON HEALTH PROGRAMS  
PATIENT DATA SHEET**



- |   |   |
|---|---|
| <input type="checkbox"/> Chewelah Community Health Center     | <input type="checkbox"/> Selkirk Community Health Center      |
| <input type="checkbox"/> Kettle River Community Health Center | <input type="checkbox"/> Springdale Community Health Center   |
| <input type="checkbox"/> Lake Spokane Health Center           | <input type="checkbox"/> Colville Community Dental Clinic     |
| <input type="checkbox"/> Loon Lake Community Health Center    | <input type="checkbox"/> Lake Spokane Community Dental Clinic |
| <input type="checkbox"/> Northport Community Health Center    | <input type="checkbox"/> Springdale Community Dental Clinic   |

PATIENT'S NAME \_\_\_\_\_  
(Last) (First) (Middle Initial)

SEX \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

VETERAN Yes  No  \_\_\_\_\_ Are you Hispanic Yes  No

RACE \_\_\_\_\_ 1=Asian 2=Black 3=White 5=American Indian 9=Other \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ MAILING ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_ HOME PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ ADDRESS \_\_\_\_\_

**APPROX. YEARLY FAMILY INCOME** \$ \_\_\_\_\_  
*This clinic is partially funded through grant funds, which enables our organization to provide medical care in your community. Income statistics are a requirement for continued funding.*

NUMBER OF FAMILY LIVING IN HOUSEHOLD \_\_\_\_\_ LIST FAMILY MEMBERS IN HOUSEHOLD \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?** \_\_\_\_\_

**PERSON RESPONSIBLE/GUARDIAN**

NAME \_\_\_\_\_  
(Last) (First) (Middle Initial)

SEX \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

HOME PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

**PRESENT INSURANCE CARD OR MEDICAL VOUCHER AT TIME OF VISIT.** I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I also authorize my insurance to pay **N.E. WASHINGTON HEALTH PROGRAMS** direct. I authorize the release of any information required for claims submitted on my behalf. The undersigned hereby consents to such treatment as may be deemed necessary by the Physician, Physician Assistant, Dentists and/or their assistants to designees for myself or minor children. I have read all the information on this sheet and have completed the above questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date