

# Wassaja Memorial Health Center

Last Name, First Middle (Maiden)		Sex	Birthdate	Social Security No.		Home Phone#	Marital Status	WMHC Chart#
Current Address (Street, City, County, State, Zip Code)					Community Name	How Long?	Is this a Reservation? Yes No	Tribe
Previous Address (City, State)			Community Name	How Long?	Is this a Reservation? Yes No	Degree Blood ¼, ½, ¾, 4/4		Agency Where Enrolled
Are you a Student? Yes No	School Attending	Full Time	Date Began School	Religion	Birthplace (City, State) If Phoenix, which hospital?			Enrollment Number
Are you a Veteran? Yes No	If yes, which Branch of Service?	Did you serve in Vietnam? Yes No	Are you still active in the Military? Yes No	Serial Number (Military)		Entry Date	Separation Date	
Next of Kin (Closest Living Relative) Name, Address, Telephone Number (If patient is a minor, indicate parent or guardian)						Internet Use? Yes No	Internet Use Where? School, Library, Work, Home, Other	
Person to Notify in an Emergency (Name, Street, City, State, Zip Code)						Telephone Number	Relationship to E Contact	
Spouse's Name (Regardless of presence in household)			Date of Birth	Tribe	Social Security No.		WMHC Chart#	
Father's Name		Tribe	Enrollment Number	Date of Birth	Date of Death	Birthplace (City, State)		
Mother's Name (Maiden Name)		Tribe	Enrollment Number	Date of Birth	Date of Death	Birthplace (City, State)		
List Everyone Who Lives With You in Your Household								
Name (Last, First, Middle)		Sex	Date of Birth	Relationship	WMHC Health Record No.	Social Security Number		
1.								
2.								
3.								
4.								
5.								
6.								
7.								
Your Employer (Name of Company, City, State)					<u>List Mother's or Guardian's Employment if Applicant is a Dependent</u>		Work Phone No.	How Long? Month/Year
Spouse's Employer (Name of Company, City, State)					<u>List Father's or Guardian's Employment if Applicant is a Dependent</u>		Work Phone No.	How Long? Month/Year
Applicant's Signature _____				Date _____	Interviewer _____			
<b>PATIENT STOPS HERE – RETURN TO THE CONTACT REPRESENTATIVE</b>								
Yes	No	Private/Work Insurance Company	Policyholder		Policy Number	Effective Date		
Yes	No	Medicare Claim Number	Part A Effective Date		Part B Effective Date			
Yes	No	Medicare Part D Claim Number	Part D Effective Date		Ethnicity:			
Yes	No	AHCCCS ID Number	Plan Name		Hispanic/Latino: Yes No		Declined to answer:	
Yes	No	Aid to Families With Dependent Children (AFDC)	Migrant Worker? Yes No		Primary Language:		Preferred Language:	
Yes	No	Supplemental Security Income (SSI)	Homeless? Yes No		Other Languages?		Interpreter required? Yes No	
Yes	No	Champus	Yes	No	Industrial Insurance		E-mail Address:	
Yes	No	Ok to receive Generic Health Information? Yes No		Preferred Method to receive reminders? Phone e-mail mail				