OFFICE USE ONLY

Eligibility: PRC _____ Direct _____

Chart #_____

Authorizing Official Initials: _____

Date Authorized: ____/____/____

YELLOWHAWK
TRIBAL HEALTH CENTER
BUSINESS OFFICE

+ Yellowhawk Tribal Health Center
46314 Timíne Way
Pendleton, OR 97801

+ P 541.966.9830
+ F 541.240.8760
+ www.yellowhawk.org

PATIENT UPDATE FORM

PLEASE FILL IN ALL SPACES. SIGN AND DATE THE BOTTOM OF THE FORM TO HAVE A COMPLETED FORM

Legal Name (First): _____ Last: _____

Date of Birth (mm/dd/yyyy): ____/____/____ Male ☐ Female ☐

Marital Status (check one): Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Separated ☐

Physical Address: _____ City _____ State ____ Zip _____

****Date moved to the above address**: ____/____/____**

Mailing Address (if different): _____ City _____ State ____ Zip _____

Cell Phone Number: _____ Home: _____ Msg. (other): _____

E-mail Address: _____ U.S. Veteran: Yes ☐ No ☐ Veteran # _____

Employer: _____ Work Ph: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Address: _____ Ph: _____

INSURANCE INFORMATION

Ins Company Name	Subscriber Name	Employer Name	Subscriber Birthdate	Subscriber Address	Policy/ID Number	Group Number

Children or Spouse Living with You: (Please check appropriate box after entering names)

Name	Husband	Wife	Son	Daughter	Niece	Nephew	Nephew	Grandchild

- I request payment of authorized benefits be made on my behalf to Yellowhawk Tribal Health Center for services furnished to me by Yellowhawk providers.
- I authorize Yellowhawk Tribal health Center and Yellowhawk Providers to release any medical information necessary for diagnosis and further treatment, or other information to process this claim. I permit a copy of this authorization to be used in place of the original.

X_____ _____

Signature of Patient, Guardian or Responsible Party — Date Signed