



Missoula Indian Center

BUILDING #33 FORT MISSOULA ROAD
MISSOULA, MT 59804
PHONE: 829-9515 FAX:829-9519

CLIENT NO. _____

FULL NAME : _____ MAIDEN OR OTHER NAME _____

ADDRESS : _____ CITY: _____ STATE : _____ ZIP CODE : _____

PHONE #: _____ WORK# _____ MESSAGE #: _____ S.S.N _____

DATE OF BIRTH _____ AGE _____ BIRTH PLACE(CITY/STATE) _____ SEX: M _____ F _____

STATUS: ENROLLED _____ DECENDANT _____ TRIBAL ENROLLMENT NO. _____ BLOOD QUANTUM _____

PRIMARY TRIBE: _____ LOCATION(CITY/STATE) _____ OTHER TRIBE(S) _____

TRIBAL QUANTUM(S) _____ Marital Status _____ DATE CLIENT MOVED TO MISSOULA _____

OTHER PERSONS LIVING IN HOUSEHOLD: NAME: _____ BIRTHDATE: _____ TRIBE/ENROLLED: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

CURRENT HEALTH INFORMATION:

DO YOU HAVE A REGULAR HEALTH CARE PROVIDER? YES _____ NO _____ DO YOU HAVE A REGULAR DENTIST? YES _____ NO _____

LIST PROVIDER NAMES AND PHONE NUMBERS _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

ARE YOUR IMMUNIZATIONS CURRENT? YES _____ NO _____ ARE YOU PREGNANT? YES _____ NO _____ DUE DATE _____

HAVE YOU EVER HAD DIABETES? _____ TYPE: _____ DATE OF DAIGNOSIS _____

IN CASE OF EMERGENCY NOTIFY: _____ PHONE NUMBER _____

TYPE OF HEALTH CARE COVERAGE:

MEDICARE "A": YES _____ NO _____ PRIVATE INSURANCE: YES _____ NO _____ CONTRACT CARE: YES _____ NO _____

MEDICARE "B": YES _____ NO _____ FULL TIME STUDENT: YES _____ NO _____ THHS DIRECT SERVICES: YES _____ NO _____

MEDICAID: YES _____ NO _____ VETERANS BENEFITS YES _____ NO _____ PRIVATE INSURANCE: YES _____ NO _____

CHIP (MT HEALTHY KIDS) YES _____ NO _____

MINOR INFORMATION TO BE FILLED OUT BY PARENT IF CLIENT IS UNDER 18

FATHER'S NAME _____ FATHER'S EMPLOYER _____

FATHERS BIRTH PLACE (CITY) _____ (STATE) _____

MOTHER'S MAIDEN NAME _____ MOTHER'S EMPLOYER _____

MOTHER'S BIRTH PLACE(CITY) _____ (STATE) _____

CERTIFICATION: I CERTIFY THAT ABOVE INFORMATION IS CORRECT:

SIGNATURE: _____ DATE: _____

