Absentee Shawnee Tribal Health Programs Intake Form
Intake form © Absentee Shawnee Tribe of Indians of Oklahoma

Note: Please print clearly and fill in every blank or check the correct response. Use "n/a" if not applicable.

Date: _____

Name:_____ Gender: M or F Date of Birth: _____

CDIB/Roll #: _____ Tribe: Absentee Shawnee Tribe SSN #: _____

E-Mail Address: _____ Home Phone:_____

Primary Address: _____ Cell Phone: _____

City, State, Zip: _____

Insurance Information

Company Name: _____ Ins. Co. Phone#: _____

Policy # _____ Group #: _____ Primary Physician:_____

Services Covered: Medical _____ Prescription: _____ Date Covered: _____

Source: Employer:_____ Type: PPO ____ HMO___ Coverage Type: Single ___ Family___

Policy-holder's relationship to patient: Self Spouse Parent Other: _____

Policy holder's Name:_____ Date of Birth_____ SSN # _____

Policy holder's Address: _____

Dental Insurance:

Company Name: _____ *Policy #* _____

*Dates Covered:*_____ *Policy Holder's Name:* _____

Vision Insurance:

Company Name: _____ *Policy #* _____

Dates Covered: _____ *Policy Holder's Name:* _____

Please attach copies of all insurance cards

ABSENTEE SHAWNEE TRIBAL
HEALTH SYSTEM
Prevention. Progress. Pride.