HRN: ________

MASHANTUCKET PEQUOT TRIBAL NATION
TRIBAL HEALTH SERVICES
75 Route 2, PO Box 3260
Mashantucket CT 06339-3260

Today's Date: ____________________

Last Name: ______________________ First Name: ______________________ Middle Initial: ______
Address: ____
City: ______________________ State: ______________________ Zip: ______________
Home Phone: (____) ______________ Social Security#: ______________________
Email Address: ____________________________ Cell Phone#: ______________________
Date of Birth: ____________________ Sex: M/F Marital Status: S____ M____ D____ W____
Primary Language: ☐English ☐Spanish ☐Other ________________
Employer Name: ______________________ Employer Phone Number: (____) ____________
Employer Address: ____
Emergency Contact Name: ______________________ Emerg. Phone #: ______________________

INSURANCE INFORMATION

PLEASE PROVIDE A CURRENT COPY OF YOUR INSURANCE CARD(S)

PRIMARY INSURANCE:
Plan Name: ____________________________ I.D. Number: ____________________________
Policy Holder: ____________________________ Effective Date: ____________________________
Claim Address: ____

SECONDARY INSURANCE:
Plan Name: ____________________________ I.D. Number: ____________________________
Policy Holder: ____________________________ Effective Date: ____________________________
Claim Address: ____

Are you Hispanic or Latino? Y☐ N☐
Are you receiving Black Lung (BL) benefits?* Y☐ N☐
Are the services to be paid by a government program or research grant?* Y☐ N☐
Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care?* Y☐ N☐
Was the illness/injury due to a work related accident or condition?* Y☐ N☐
Was the illness/injury due to an automobile accident?* Y☐ N☐
Are you entitled to Medicare based on?
Age? Y☐ N☐ Disability? Y☐ N☐ ESRD? Y☐ N☐

If you have answered yes to any of these questions, please notify the receptionist.

______________________________ ______________________ ______________
Patient (or Responsible Party if under 18 years old) Relationship Date

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Please read and sign back of form