APPLICATION FOR MEDICAL SERVICES

PIMC FORM-58 ASSIGNED PIMC CHART#

SECTION A PATIENT DEMOGRAPHIC INFORMATION

Patient Name:	[LAST]	[FIRST]	[MIDDLE INITIAL]	Patient Sex:	[ ] MALE [ ] FEMALE
Other Names Used:		Date of Birth:	Place of Birth:		Social Security#
Address: Apt #		City:	State:		Zipcode:
Community Name:	How long has Child lived at this address?		Is this on a Reservation?		Religion:
Home Phone#:	Cell or Message Phone#:		Which Reservation?		

SECTION B PATIENT TRIBAL INFORMATION

Child is: [ ]Enrolled Tribal Member [ ]Enrollment is Pending [ ]A descendent of an Enrolled Member	Tribe Name:	Agency enrolled at:
	Enrollment/Census#:	

Father's Name: [Last]	[First]	[Middle Initial]	Date of Birth:	Place of Birth:
Father's Tribal Affiliation?	Enrollment/Census#		Date of Death:	Social Security#:
Mother's Maiden Name [Last]	[First]	[Middle Initial]	Date of Birth:	Place of Birth:
Mother's Tribal Affiliation?	Enrollment/Census#		Date of Death:	Social Security#:

SECTION C MOTHER'S EMPLOYMENT INFORMATION

Is Mother Employed? [ ] Yes [ ]No	If No, how long?		Does Mother receive: [ ]GA [ ]Other [ ]AFDC-Foodstamps [ ]Land Lease
Employer Name:	How long with employer?		Employer Phone#
City	State	Zipcode:	
Mother's Cell Phone#	Alternate Ph #	Email Address:	
Is Mother a Student? [ ]Yes [ ]No [ ]Full-time [ ]Part-time	If yes, where?	How long?	Does Mother receive? [ ]Pell Grant [ ]Tribal Grant [ ]Scholarship [ ]Other

SECTION D FATHER'S EMPLOYMENT INFORMATION

Is Father employed? [ ] Yes [ ] No	If No, how long?		Does Father receive: [ ]GA [ ]Other [ ]AFDC-Foodstamps [ ]Land Lease
Father's Employer Name:	How long with employer?		Employer Phone#:
City	State	Zipcode:	
Father's Cell Phone#	Alternate Ph#	Email Address:	
Is Father a Student? [ ]Yes [ ]No [ ]Full-time [ ]Part-time	If yes, where?	How long?	Does Father receive? | |Pell Grant | |Tribal Grant | |Scholarship | |Other

I certify that the information provided on this form is true to the best of my knowledge.

_____ _____

Signature Date

_____

Relationship to Parent

SECTION F CONTACT INFORMATION

Person who can be contacted in the event of an emergency:

Name:	Relationship:		Phone#
Address: Apt #	City:	State:	Zipcode:

Next of Kin (Different from your Emergency Contact above)

Name:	Relationship:		Phone#
Address: Apt #	City:	State:	Zipcode:

SECTION G ALTERNATE RESOURCE INFORMATION

MEDICARE PROGRAM

Do you currently have Medicare? [ ]Yes [ ]No	Medicare Number:

AHCCCS or Out-of State MEDICAID Program

Are you currently enrolled with the Arizona AHCCCS Program? [ ]Yes [ ]No	If yes, please give Health Plan Name: [ ]American Indian Health Plan [ ]Phoenix Health Plan [ ]Mercy Care Plan [ ]Health Choice of AZ [ ]Maricopa Health Plan [ ]Kidscare [ ]Care First Health Plan [ ]Arizona Physicians IPA [ ]Other_____
If you are not enrolled in the Arizona AHCCCS Program, are you enrolled in another state? [ ]Yes [ ]No State:_____	

PRIVATE INSURANCE

Are you covered under a Private Insurance Plan? [ ]Yes [ ]No	If yes, what is the name of your insurance?	
Who is the primary insured (policy holder)?	Their Social Security Number:	Date of Birth:

SECTION H NEW HEALTH INITIATIVE PROJECT - Electronic Health Record

Do you access the Internet: [ ] YES [ ] NO

If yes, where?

[ ] HOME [ ] HEALTH CARE FACILITY [ ] MOBILE DEVICE
[ ] WORK [ ] LIBRARY
[ ] SCHOOL [ ] TRIBE

Do you have an email address: [ ] YES [ ] NO

EMAIL ADDRESS:

Do we have permission to send generic health information to your email address? [ ] YES [ ] NO

What is your preferred method to receive reminders?

[ ] PHONE [ ] EMAIL [ ] MAIL

ETHNICITY:

RACE:

PRIMARY LANGUAGE: **INTREPRETER REQUIRED?**

OTHER LANGUAGE SPOKEN:

PREFERRED LANGUAGE:

MIGRANT WORKER: [ ] YES [ ] NO If yes, care you a seasonal worker?

HOMELESS? [ ] YES [ ] NO