

ADULT

PHOENIX INDIAN MEDICAL CENTER

ADULT

APPLICATION FOR MEDICAL SERVICES

PIMC-58

ASSIGNED PIMC CHART#

SECTION A PATIENT DEMOGRAPHIC INFORMATION

| | | | |
|---|--|--|---|
| Patient Name: [LAST] [FIRST] [MIDDLE INITIAL] | | Patient Sex: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | |
| Other Names Used: | Date of Birth: | Place of Birth: | Social Security# |
| Address: | Apt # | City: | State: Zipcode: |
| Community Name: | How long have you lived at this address? | Is this on a Reservation? | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/> Significant Other |
| Home Phone#: | Cell or Message Phone#: | Which Reservation? | |

SECTION B PATIENT TRIBAL INFORMATION

| | | |
|---|-------------|---------------------|
| Are you: <input type="checkbox"/> Enrolled Tribal Member <input type="checkbox"/> Enrollment is Pending <input type="checkbox"/> A decedent 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: |
| Mother's [Last] [First] [Middle Initial] Maiden Name | Date of Birth: | Place of Birth: |
| Mother's Tribal Affiliation? | Enrollment/Census# | Date of Death: |

SECTION C EMPLOYMENT INFORMATION

| | | |
|---|-------------------------|---|
| Are you employed: <input type="checkbox"/> Yes <input type="checkbox"/> No | If No, how long? | Do you receive: <input type="checkbox"/> GA <input type="checkbox"/> Other <input type="checkbox"/> AFDC-Foodstamps <input type="checkbox"/> Land Lease |
| Employer Name: | How long with employer? | Employer Phone# |
| City | State | Zip Code |
| Are you a Student? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time | If yes, where? | How long? |
| | | Do you receive: <input type="checkbox"/> Pell Grant <input type="checkbox"/> Tribal Grant <input type="checkbox"/> Scholarship <input type="checkbox"/> Other |

SECTION D SPOUSE/SIGNIFICANT OTHER INFORMATION

| | | | |
|--|---|------------------------|---|
| Spouse/Significant Other Name: | Date of Birth: | SSN: | PIMC# |
| Is Spouse/Significant Other employed? <input type="checkbox"/> Yes <input type="checkbox"/> No | If No, how long? | | |
| Employer Name: | How long have they been with this Employer? | Their Employer Phone#: | |
| City | State | Zip Code | |
| Is spouse/Significant Other a Student? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time | If yes, where? | How long? | Does Spouse/Signif. Other receive: <input type="checkbox"/> Pell Grant <input type="checkbox"/> Tribal Grant <input type="checkbox"/> Scholarship <input type="checkbox"/> Other |

SECTION E MILITARY SERVICE

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| Were you ever in any Military Service? <input type="checkbox"/> YES <input type="checkbox"/> NO | If yes, which Branch? | Claim# | Vietnam Veteran <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Entry Date: | Seperation Date: | Service Connected <input type="checkbox"/> YES <input type="checkbox"/> NO |

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

Signature

Date

OVER ➤

SECTION I 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 II ALTERNATE RESOURCE INFORMATION

MEDICARE PROGRAM

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| Do you currently have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No | Medicare Number: |
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| Are you currently 65 years or older? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No |
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AHCCCS or Out-of-State MEDICAID Program

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| Are you currently enrolled with the Arizona AHCCCS Program? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please give Health Plan Name: |
|---|---------------------------------------|

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| If you are not enrolled in the Arizona AHCCCS Program, are you enrolled in another state? <input type="checkbox"/> Yes <input type="checkbox"/> No State: _____ | <input type="checkbox"/> American Indian Health Plan | <input type="checkbox"/> Phoenix Health Plan |
| | <input type="checkbox"/> Mercy Care Plan | <input type="checkbox"/> Health Choice of AZ |
| | <input type="checkbox"/> Maricopa Health Plan | <input type="checkbox"/> Kidscare AHCCCS |
| | <input type="checkbox"/> Care First Health Plan | |
| | <input type="checkbox"/> Arizona Physicians IPA | <input type="checkbox"/> Other |

PRIVATE INSURANCE

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| Are you covered under a Private Insurance Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, what is the name of your insurance? |
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| Who is the primary insured (policy holder)? | Their Social Security Number: | Date of Birth: |
|---|-------------------------------|----------------|

SECTION III NEW HEALTH INITIATIVE PROJECT - Electronic Health Record

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| Do you access the Internet? <input type="checkbox"/> YES <input type="checkbox"/> NO |
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| If yes, where? <input type="checkbox"/> HOME <input type="checkbox"/> HEALTH CARE FACILITY <input type="checkbox"/> MOBILE DEVICE <input type="checkbox"/> WORK <input type="checkbox"/> LIBRARY <input type="checkbox"/> SCHOOL <input type="checkbox"/> TRIBE |
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| Do You have an email address? <input type="checkbox"/> YES <input type="checkbox"/> NO |
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| EMAIL ADDRESS: |
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| Do we have permission to send generic health information to your email address? <input type="checkbox"/> YES <input type="checkbox"/> NO |
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| What is your preferred method to receive reminders? <input type="checkbox"/> PHONE <input type="checkbox"/> EMAIL <input type="checkbox"/> MAIL |
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| ETHNICITY: |
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| RACE: |
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| PRIMARY LANGUAGE: | INTERPRETER REQUIRED? |
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| OTHER LANGUAGE SPOKEN: |
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|---------------------|--|------------------------------------|
| PREFERRED LANGUAGE: | MIGRANT WORKER? <input type="checkbox"/> YES <input type="checkbox"/> NO | If yes, are you a seasonal worker? |
| | HOMELESS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |

