GRAND RONDE HEALTH & WELLNESS CENTER
9605 Grand Ronde Road, Grand Ronde, OR 97347
1-800-775-0095 or 503-879-2096
Fax 503-879-2071

Individual Registration Form

OFFICE USE ONLY
Patient Eligibility Status
- ○ CHS / Direct
- ○ Direct / Tribal
- ○ Direct / Other Indian
- ○ Direct / Tribal Descendant
- ○ Direct / Other Descendant
- ○ Ineligible

Chart # _____
Tribe _____
Roll # _____
Tribal Quantum: _____

* Official Signature_____DATE_____

A. PATIENT INFORMATION

Patient Legal Name: _____
Last First Middle

Date of Birth: _____ Social Security # _____-_____-_____ Full Time Student ☐ Yes ☐ No

☐ Male ☐ Female ☐ Non-binary ☐ Transgender ☐ Other_____

Home Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

County of Residence _____ Email Address (Req. for Patient Portal):_____

Phone: (_____) _____-_____☐ Home Phone: (_____) _____-_____ ☐ Cell Preferred Appt Reminder ☐ Text ☐ Call

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Separated

Member of a Federally Recognized Tribe? ☐ Yes ☐ No Tribe of Membership: _____

Tribal Enrollment # _____ Tribal Blood Quantum _____ Preferred Language _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Unknown ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

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Mother's Maiden Name: _____ Father's Name: _____

Spouse/Parent: _____ Social Security # _____-_____-_____
Last First Middle

Spouse/Parent Address: _____
Street City State Zip Code

Are You a Veteran? ☐ Yes ☐ No Branch _____If a veteran, please provide your benefit card.

B. INSURANCE INFORMATION

Primary Insurance Co. _____ Policy # _____ Group # _____

Name of Insured: _____ Address _____
Street City State Zip Code

DOB of Insured: _____

Secondary Insurance Co. _____ Policy # _____ Group # _____

Name of Insured: _____ Address _____
Street City State Zip Code

C. IN CASE OF EMERGENCY

Relative to contact (other than spouse) _____ Phone: (_____) _____-_____

Other Person to contact (not relative) _____ Phone: (_____) _____-_____

Signature _____ Date _____

******ATTENTION ENROLLED CTGR MEMBERS ONLY: PLEASE FILL OUT THE BACK SIDE******

Skookum Health/Dental Application

TM ☐ Medical/Dental/Vision Pharmacy_____
SP ☐ Medical/Vision/Pharmacy _____
NEWBORN _____

Clinic – Barbara Steere
9605 Grand Ronde Rd.
Grand Ronde, Or 97347
Phone: (800)-749-2928
Fax: (503) 879 -2228

SPOUSE OR NEWBORN NAME & ID# _____

CHECK ALL APPLICABLE BOXES FOR ENROLLMENT OR CHANGE:					
☐	Become enrolled	☐	Change other insurance info	☐	ID Card Request
☐	Change name	☐	Add Benefit	☐	Terminate Coverage
☐	Change Address	☐	TEMP Status for Newborns	☐	Add Spouse Benefit

Please fill in Tribal Member information below for Spousal or Newborns that are enrolling in the Skookum Health Program.

Tribal Member Last Name	First Name	Roll #	Birth Date / /

Section 1 – Employment Information

Are you employed? ☐ No ☐ Yes
☐ Full time ☐ Part Time
If yes, complete the following:
Name of Employer: _____
Address: _____
Phone: _____
Are you eligible for your Employer sponsored insurance?
☐ **No** ☐ **Yes**
If no, please explain: _____
If Yes, monthly premium $_____

Is your spouse employed? ☐ No ☐ Yes
☐ Full time ☐ Part Time
Name of Employer: _____
Address: _____
Phone: _____
Are you eligible for your spouses Employer sponsored insurance?
☐ **No** ☐ **Yes**
If no, please explain: _____
If Yes, monthly premium $_____

Section 2– Acknowledgement

Any misrepresentation or misstatement of a material fact made on this form or any other form requesting benefits under the plan shall terminate a member's eligibility render invalid all benefits under the plan and require forthwith repayment of any benefit received pursuant to such misrepresentation or misstatement.

_____ _____
Member Signature *(Parent if member is under 18 - print)* Date

Skookum Health Plan Use Only

Received by	Date received
Original Effective Date	Termination Date
Spouse? ☐ YES ☐ NO	If yes, is spouse eligible? ☐ YES ☐ NO
Comments:	