Baker School-Based Health Center

2500 E Street
Baker City, OR 97814
541-524-2646

Primary Care Doctor/Clinic: _____

Student Name: _____ Gender: M F DOB _____
Last First M.I

SSN: _____ Grade: _____ School Attending: _____

Language: _____ Needs Interpreter? No Yes Ethnicity: Hispanic Non-Hispanic

Race: Alaskan Native American Indian Asian Black Native Hawaiian Pacific Islander White Unknown Decline

Home Phone: (_____)-_____ Student Cell: (_____)-_____

Address: _____

City: _____ State: _____ Zip: _____

GUARANTOR ACCOUNT: (Person financially responsible for account) If also **EMERGENCY CONTACT** ✓ here ☐

Name: _____ DOB _____

Address: _____

SSN: _____ Relationship: _____ Phone Number: (_____)-_____

PRIMARY INSURANCE ACCOUNT/COVERAGE: (Please complete all fields)

Account:
Insurance Name: _____Subscriber ID:_____
Coverage:
Subscriber Name: _____Group #: _____
Last First M.I

Subscriber DOB: _____ Subscriber Social Security #: _____

SECONDARY INSURANCE ACCOUNT/COVERAGE:

Account:
Insurance Name: _____Subscriber ID:_____
Coverage:
Subscriber Name: _____Group #: _____
Last First M.I

Subscriber DOB: _____ Subscriber Social Security #: _____

IF EMERGENCY CONTACT IS DIFFERENT FROM ABOVE:

Name: _____ Relationship: _____

Address: _____

Home: (_____)-_____ Cell: (_____)-_____ Work: (_____)-_____

08/15/2019