HEALTH & ALLERGY

MEMBER INFORMATION

Full Name: _____ Date of Birth: _____

Phone Number: _____ Gender: ☐ Male ☐ Female ☐ Other

Physicians Name _____

Phsyicians Number: _____

Hospital Preference: _____

Medical Insurance: ☐ Yes ☐ No

Personal Medical History (Check all that apply):

☐ Anxiety ☐ Diabetes ☐ Depression ☐ Migraine

☐ Asthma ☐ Seizures ☐ No known medical conditions

☐ Other: _____

Please list any medications you are currently taking:

_____

_____

Do you have any known allergies? ☐ Yes ☐ No

If yes, list allergies: _____

_____

_____

_____

Signature: By signing below, I confirm that the information provided is accurate to the best of my knowledge.

Signature: _____

Date: _____ / _____ / _____

Boys & Girls Club
OF THE IOWA TRIBE
OF KS & NE