



YEARLY UPDATE

PLEASE COMPLETE AND RETURN TO CONTRACT HEALTH SERVICES

CLIENT ADDRESS AND INFORMATION

NAME: _____ DOB: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE# _____ CELL# _____ WORK# _____

PRIMARY INSURANCE:

POLICY HOLDER: _____

POLICY NUMBER: _____

EMERGENCY CONTACT:

NAME: _____ RELATION TO YOU: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE# _____ CELL# _____ WORK# _____

I HEREBY AUTHORIZE CONTRACT HEALTH SERVICES (CHS) STAFF TO OBTAIN PERSONAL/FINANCIAL INFORMATION NECESSARY TO ASSIST IN COMPLETEING MY CHS FILE AND TO HELP ATTAIN ALTERNATE HEALTH COVERAGE RESOURCES.

SIGNATURE: _____ DATE: _____

CONTRACT HEALTH SERVICES
1821 N LECLERC ROAD #2, CUSICK, WA 99119
DEBORAH FLETT - COORDINATOR
OFFICE: 509-447-7117 CELL: 509-385-2918