

OUTPATIENT RECORD INFORMATION

PLEASE PRINT ALL INFORMATION CLEARLY

DATE: _____

1. PATIENT INFORMATION

(MM/DD/YY)

FULL NAME: _____
(LAST) (FIRST) (MI)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE: _____ WORK: _____ DOB: _____
(MM/DD/YY)

PATIENT'S SEX: _____ ORGAN DONOR: YES NO
(CIRCLE ONE)

2. SPONSOR INFORMATION

DOB: _____
(MM/DD/YY)

FULL NAME: _____
(LAST) (FIRST) (MI)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

ACTIVE DUTY RETIRED BRANCH OF SERVICE: _____ RANK/RATE: _____
(CIRCLE ONE) IF ACTIVE, LIST CURRENT DUTY STATION: _____

HOME PHONE: _____ DUTY PHONE: _____

3. RELATIONSHIP OF PATIENT TO SPONSOR (CIRCLE ONE)

SPONSOR SPOUSE SPONSOR'S 1ST CHILD SPONSOR'S 2ND CHILD
SPONSOR'S 3RD CHILD OTHER CHILDREN #: _____ (INCLUDE ALL STEPCHILDREN)
OTHER: _____

4. ACTION REQUESTED (CIRCLE ONE)

NEW DEPENDENT NEWLY RETIRED MILITARY NO PREVIOUS RECORD
PREVIOUS RECORD LOST
NEW SPONSOR (CHANGE EXISTING HEALTH RECORD) PREVIOUS SPONSOR'S INFORMATION
NAME: _____

OFFICIAL USE ONLY: DEERS CHECK COMPUTER ENTRY RECORD MADE

DATE IN: _____ DATE DONE: _____ NHOH 6150/22 (05-11)