KIAMICHI
FAMILY MEDICAL CENTER
Family Caring for Family

PATIENT REGISTRATION FORM

As a Federally Qualified Health Center, KFMC is required to collect demographic information regarding the patients we serve. The information you provide is confidential. Thank you for choosing KFMC as your health care provider.

Patient Information

FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____

DATE OF BIRTH: _____/ _____/ _____ SOCIAL SECURITY NUMBER: _____-_____-_____

MAILING ADDRESS: _____CITY: _____STATE: _____ZIP: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____

PREFERRED METHOD OF CONTACT (CHECK ONE): ☐PHONE CALL ☐TEXT MESSAGE

PREFERRED PHONE: ☐Home ☐Cell

DO YOU HAVE MEDICAL/DENTAL INSURANCE: ☐NO ☐YES (If yes, present information to receptionist)

NUMBER OF INDIVIDUALS IN HOUSEHOLD: _____

HOUSEHOLD INCOME LEVEL:

☐ $0 - $11,999 ☐$12,000 - $19,999 ☐$20,000 - $27,999 ☐ $28,000 - $35,999 ☐$36,000 - $39,999

☐$40,000 - $47,999 ☐$50,000 - $57,999 ☐$58,000 - $61,999 ☐$62,000 and up

YOU MAY BE ELIGIBLE FOR A DISCOUNT BASED ON HOUSEHOLD INCOME. IF YOU WOULD LIKE TO APPLY, SPEAK WITH A RECEPTIONIST.

PRIMARY LANGUAGE (CHECK ONE): ☐ENGLISH ☐SPANISH ☐OTHER: _____

DO YOU NEED A TRANSLATOR? ☐NO ☐YES

EMAIL (IF YOU WOULD LIKE PATIENT PORTAL): _____

GENDER AT BIRTH (CHECK ONE):

☐FEMALE ☐MALE

GENDER IDENITY TODAY (CHECK ONE):

☐FEMALE ☐MALE ☐OTHER ☐TRANSGENDER MALE/FEMALE-TO-MALE ☐TRANSGENDER FEMALE/MALE-TO-FEMALE

MARITAL STATUS (CHECK ONE):

☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐LEGALLY SEPARATED

SEXUAL ORIENTATION (CHECK ONE):

☐STRAIGHT ☐LESBIAN/GAY ☐BISEXUAL ☐SOMETHING ELSE ☐DON'T KNOW ☐WILL NOT DISCLOSE

RACE (CHECK ALL THAT APPLY):

☐ASIAN INDIAN ☐CHINESE ☐FILIPINO ☐JAPANESE ☐KOREAN ☐VIETNAMESE ☐OTHER ASIAN

☐NATIVE HAWAIIAN ☐OTHER PACIFIC ISLANDER ☐GUAMANIAN/CHAMORRO ☐SAMOAN

☐BLACK/AFRICAN AMERICAN ☐AMERICAN INDIAN/ALASKA NATIVE ☐WHITE/CAUCASIAN ☐ WILL NOT DISCLOSE

ETHNICITY (CHECK ONE):

☐WILL NOT DISCLOSE ☐NON-LATINO/NON-HISPANIC ☐MEXICAN/MEXICAN AMERICAN, CHICANO/A

☐PUERTO RICAN ☐CUBAN ☐ANOTHER HISPANIC, LATINO/A OR SPANISH ORIGIN

SEASONAL WORKER? ☐NO ☐YES **MIGRANT WORKER?** ☐NO ☐YES

EMPLOYMENT STATUS (CHECK ONE):

☐STUDENT ☐UNEMPLOYED ☐ RETIRED ☐ACTIVE MILITARY DUTY ☐EMPLOYED

IF EMPLOYED, NAME OF EMPLOYER: _____

ARE YOU A MILITARY VETERAN? ☐NO ☐YES

DO YOU LIVE IN PUBLIC HOUSING? ☐NO ☐YES

HOMELESS STATUS:

☐NOT HOMELESS ☐DOUBLING UP ☐STREET ☐HOMELESS SHELTER ☐PERMANENT SUPPORTIVE HOUSING

☐TRANSITIONAL ☐OTHER: _____

PRIMARY PHARMACY NAME: _____

PHARMACY ADDRESS/CITY: _____

PHARMACY PHONE NUMBER: (_____) _____-_____

EMERGENCY CONTACT

FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____

RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____/ _____/ _____

MAILING ADDRESS: _____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY -REVIEWER INITIALS: _____