



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: _____

CELL PHONE: (____) ____-____ ALT PHONE: (____) ____-____

EMAIL (IF YOU WOULD LIKE PATIENT PORTAL): _____

GENDER AT BIRTH (CHECK ONE):

FEMALE MALE

MARITAL STATUS (CHECK ONE):

SINGLE MARRIED DIVORCED WIDOWED LEGALLY SEPARATED

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

DO YOU NEED A TRANSLATOR? NO YES

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 (**must specify**): _____

PRIMARY PHARMACY NAME: _____

PHARMACY ADDRESS/CITY: _____

PHARMACY PHONE NUMBER: (____) ____-____

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

***NUMBER OF INDIVIDUALS IN HOUSEHOLD:** _____ (Include yourself, spouse/partner, children, and anyone else who lives with you)

HOUSEHOLD INCOME LEVEL:

- \$0 - \$11,999 \$12,000 - \$19,999 \$20,000 - \$27,999 \$28,000 - \$35,999 \$36,000 - \$39,999
 \$40,000 - \$49,999 \$50,000 - \$57,999 \$58,000 - \$61,999 \$62,000 and up

YOU MAY QUALIFY FOR A DISCOUNT BASED ON HOUSEHOLD INCOME, EVEN IF YOU HAVE INSURANCE. TO APPLY OR LEARN MORE, PLEASE SPEAK WITH A RECEPTIONIST.

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: _____

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: _____