KIAMICHI
FAMILY MEDICAL CENTER

PATIENT REGISTRATION FORM

SECTION I

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(CIRCLE ONE): PHONE CALL OR TEXT MESSAGE **Preferred phone(Circle one):** Home or Cell

WOULD YOU LIKE TO HAVE ACCESS TO YOUR ONLINE PATIENT PORTAL? YES or NO

IF YES, PLEASE PROVIDE YOUR EMAIL: _____

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

DO YOU NEED A TRANSLATOR? YES or NO

GENDER AT BIRTH (CIRCLE ONE): FEMALE or MALE

GENDER IDENITY TODAY(CIRCLE ONE) : FEMALE MALE OTHER
TRANSGENDER MALE/FEMALE-TO-MALE TRANSGENDER FEMALE/MALE-TO-FEMALE

MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED WIDOWED LEGALLY SEPARATED

SEXUAL ORIENTATION (CIRCLE ONE): STRAIGHT LESBIAN/GAY BISEXUAL SOMETHING ELSE DON'T KNOW

RACE (CIRCLE ALL THAT APPLY): AFRICAN AMERICAN/BLACK ASIAN CAUCASIAN/WHITE NATIVE AMERICAN
NATIVE HAWAIIAN OTHER PACIFIC ISLANDER

ETHNICITY (CIRCLE ONE): LATINO/HISPANIC NON-LATINO/NON-HISPANIC

ARE YOU A MILITARY VETERAN? YES or NO

EMPLOYMENT STATUS (CIRCLE ONE): STUDENT UNEMPLOYED RETIRED ACTIVE MILITARY DUTY EMPLOYED

IF EMPLOYED, NAME OF EMPLOYER: _____

PRIMARY PHARMACY NAME: _____ **PHARMACY ADDRESS:**_____

PHARMACY PHONE NUMBER: (_____) _____-_____

SECTION II

FAMILY INCOME

Because we are partially funded by a federal grant, we are asked to collect income information. Please determine the number of persons in your household and check your annual (yearly) income range. This information is for generalized reporting regarding the health center, **NO PERSONAL INFORMATION IS SHARED**.

NUMBER OF PEOPLE IN YOUR HOUSEHOLD: _____

Range 1 ( ) $0 to 20, 000	Range 2 ( ) $20, 001 to $40,000	Range 1 ( ) $40, 001 to $60,000	Range 1 ( ) $60, 001 to $80,000	Range 1 ( ) $80,001 to $100,000	Range 1 ( ) $100,001+

SECTION III - **LEGAL GUARDIAN INFORMATION MUST BE COMPLETED IF PATIENT IS UNDER 18 YEARS OF AGE**

RELATIONSHIP TO PATIENT: _____

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

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

MAILING ADDRESS: _____

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

SECTION IV- EMERGENCY CONTACT

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

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

MAILING ADDRESS: _____

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

SECTION V - PATIENT INSURANCE INFORMATION

PLAN I - PRIMARY

INSURANCE COMPANY: _____ MEMBER ID: _____

GROUP #: _____ COPAY: $_____

SUBSCRIBER INFORMATION FOR THIS INSURANCE PLAN

☐ **USE PATIENT**
NO NEED TO COMPLETE THE REST OF THIS PLAN

PATIENT'S RELATIONSHIP TO SUBSCRIBER:_____

SUBSCRIBER NAME: _____ **DATE OF BIRTH:** _____/ _____/ _____

SUBSCRIBER ADDRESS:_____

PLAN II - SECONDARY

INSURANCE COMPANY: _____ MEMBER ID: _____

GROUP #: _____ COPAY: $_____

SUBSCRIBER INFORMATION FOR THIS INSURANCE PLAN

☐ **USE PATIENT**
NO NEED TO COMPLETE THE REST OF THIS PLAN

PATIENT'S RELATIONSHIP TO SUBSCRIBER:_____

SUBSCRIBER NAME: _____ **DATE OF BIRTH:** _____/ _____/ _____

SUBSCRIBER ADDRESS:_____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY -REVIEWER INITIALS: _____