PATIENT REGISTRATION FORM

Family Medicine Health Center (FMHC) is a Federally Qualified Health Center and receives federal funding pursuant to Section 330 of the Public Health Service Act.
We are required to collect information about age, gender, race, sexual orientation, income, and family size for statistical purposes only. No individual information is submitted.

FAMILY MEDICINE HEALTH CENTER

PATIENT INFORMATION

Last Name:	First Name:	M.I.	Marital Status: (Choose One) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er)
Mailing Address:			Social Security No.:
City:	State:	ZIP:	Home Phone: / Cell Phone:
E-Mail:	Employer:		Work Phone:

Contact for Reminder Calls and Other Electronically Generated Messages: (Choose One) ☐ Text ☐ Voice (Select Preferred Number: ☐ Home ☐ Cell ☐ Work

Race: (Choose One)
☐ Asian ☐ American Indian
☐ Black/African American ☐ Alaska Native
☐ White/Caucasian ☐ Multi-Racial
☐ Native Hawaiian ☐ Refused to Report
☐ Other Pacific Islander

Ethnicity: (Choose One)
☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Refused to Report

Birth Date:
/ /
MO / DAY / YR
Age:

Birth Sex:
☐ Male
☐ Female
☐ Non-Binary
☐ Unknown

Gender Identity:
☐ Female
☐ Male
☐ Transgender Female / Male-to-Female
☐ Transgender Male / Female-to-Male
☐ Other
☐ Choose Not to Disclose
☐ Non-Binary / Gender Queer
☐ Questioning

Preferred Pronouns:
☐ She/Her/Hers
☐ He/Him/His
☐ They/Them/Theirs
☐ Ze/Hir/Hirs
☐ Ey/Em/Eirs
☐ Xe/Sem/Xyrs
☐ Ve/Vir/Vis
☐ Other
☐ Patient's Name
☐ Unknown

Veteran Status: ☐ Veteran ☐ Non-Veteran | Preferred Language:

Family Size (Including Self): | Annual Household Income:

Living Status:
☐ Own ☐ Doubling Up
☐ Rent ☐ Street
☐ Public Housing ☐ Unknown
☐ Homeless Shelter ☐ Other:
☐ Transitional

Farmworkers:
Has anyone in your household worked in agriculture (fields, orchards, etc.) in the past 2 years? ☐ Yes ☐ No
If yes, did that person work for less than 12 months out of the year? ☐ Yes ☐ No
If yes, did that person move from place to place for work? ☐ Yes ☐ No
Is anyone in your household a retired farmworker? ☐ Yes ☐ No

For each statement, please tell me whether the statement was "often true, sometimes true, or never true" for your household:
Within the past 12 months, we worried whether our food would run out before we got money to buy more. ☐ Often True ☐ Sometimes True ☐ Never True ☐ Don't Know, or Refused
Within the past 12 months, the food we bought just didn't last and we didn't have money to get more. ☐ Often True ☐ Sometimes True ☐ Never True ☐ Don't Know, or Refused

RESPONSIBLE PARTY

Person Responsible:	Birth Date: / /	Address (if different):	Home Phone:
Occupation:	Employer:	Employer Address:	Employer Phone:

Is this person a patient of FMHC? ☐ Yes ☐ No | Is this patient covered by Insurance? ☐ Yes ☐ No

INSURANCE INFORMATION *(Please give your insurance card to the Receptionist)*

Name of Primary Insurance: ☐ IPN ☐ Tricare ☐ Blue Cross ☐ Blue Shield ☐ Medicare ☐ Medicaid ☐ Other:

Primary Medical Insurance			Secondary Medical Insurance		
Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Subscriber's Name:	Subscriber's SSN:	Birth Date: / /
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Friend ☐ Partner ☐ Dependent ☐ Parent ☐ Other			Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Friend ☐ Partner ☐ Dependent ☐ Parent ☐ Other		

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address):	Relationship to Patient:	Phone Number:	Alternate Phone Number:

NOTE: MEDICARE SECONDARY RECIPIENTS NEED TO COMPLETE THE NEXT SECTION

- ☐ Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
- ☐ Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
- ☐ Medicare Secondary, Other Liability Insurance is Primary
- ☐ Medicare Secondary, No-fault Insurance including Auto is Primary
- ☐ Medicare Secondary Worker's Compensation
- ☐ Medicare Secondary Veteran's Administration
- ☐ Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan
- ☐ Medicare Secondary Public Health Service (PHS) or Other Federal Agency
- ☐ Medicare Secondary Black Lung

FOR FMHC STAFF USE ONLY

If the patient or guardian refuses to sign/complete this form, please complete this section. Date offered to patient: / / FMHC Staff Initials: