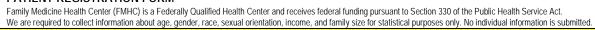
PATIENT REGISTRATION FORM





PATIENT INFORMATION												
Last Name:	First Name:					M.I.	Marital Status: (Choose One)					
										☐ Divorced ☐ Separated ☐ Widow(er)		
Mailing Address:		So	ial Secu	ırity No.:								
City:			State: ZIP			Home Phone:		•		Cell Phone:	ell Phone:	
E-Mail:					Employer:					Work Phone:		
Contact for Reminder Calls and Other Electronically Generated Messages: (Choose One)											Cell D Work	
Race: (Choose One) Ethnicity: (Choose On				Birth D		Gender Identity:				Preferred Pronouns:		
☐ Asian ☐ American Indian ☐ His				/	1	Female					☐ She/Her/Hers	
☐ Black/African American ☐ Alaska Native		ot Hispanic/Latino		MO / DAY / YR		□ Male					☐ He/Him/His	
☐ White/Caucasian ☐ Multi-Racial):		Fransgender Female				☐ They/Them/Theirs	
☐ Native Hawaiian ☐ Refused to Re☐ Other Pacific Islander	eport				JCA.		☐ Transgender Male / Female-to-Ma			☐ Ze/Hir/Hirs ☐ Ey/Em/Eirs		
Utilei Facilic Islandei		=			T Observe Notte Die			se		□ Xe/Se		
					☐ Female ☐ Non-Binary		□ Non-Binary / Gender Queer			□ Ve/Vir		
					nown	☐ Questioning				☐ Other ☐ Patient's Name		
Veteran Status: ☐ Veteran ☐ Non-Veterar	n Drofe	rrod La	anguago:							□Unkno	WII	
Veteran Status: ☐ Veteran ☐ Non-Veteran Preferred Language: Family Size (Including Self): Annual Household Income: Living Status:												
Farminy Size (including Seit): Affilial Household income: Living Status Farmworkers:										☐ Doubling Up		
Has anyone in your household worked in agriculti	ure (fields, orchar	ds. etc.)) in the past 2	2 vears?			☐ Yes ☐ No	□Rer			□ Street	
If yes, did that person work for less than 12 months out of the year? ☐ Yes ☐ No ☐ Public Housing										g □ Unknown		
If yes, did that person move from place to place for work?										helter		
Is anyone in your household a retired farmworker?												
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.												
RESPONSIBLE PARTY												
Person Responsible: Birth Date: Address (different):					Home Phone:	
			1 1									
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 Medica								dary Med				
Subscriber's Name:	Subscriber's SSN: Birth Date			e: /	Subscriber's Name:				Subscriber's SSN: Birth Date:		Birth Date:	
Patient's Relationship to Subscriber: Patient's Relationship to Subscriber: Self Spouse Child Friend Partner Dependent Parent Other Other										rent 🗆 Other		
·	·		IN CA	SE OF	EMERGEN (ĊΥ						
Name of Local Friend or Relative (not living at same address): Relationship to							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 Heal						ı pen	ou with all employ	cı s yıvl	ıh ucallu	μαιι		
☐ Medicare Secondary Black Lung) or Ol	uici i cutia	ı Aycılcy	•							
FOR FMHC STAFF USE ONLY												
FOR FMHC STAFF USE ONLY If the patient or quardian refuses to sign/complete this form, please complete this section. Date offered to patient: / / FMHC Staff Initials:												