Klamath Tribal Health & Family Services
Patient Registration Form

Please PRINT in Legible Handwriting

KTHFS Use Only
❑ New ❑ Update
Chart Number

Patient Information

1. _____ **2.** _____
Full Legal Name — Maiden Name/Other Name Used/Nickname

3. _____ **4.** _____ **5.** _____ **6.** _____
Sex — Date of Birth — Social Security Number — City & State of Birth

7. _____ _____ _____ _____
Mailing Address — City — State — Zip Code

8. _____ _____ _____ _____
Physical Address (If Different from Mailing Address) — City — State — Zip Code

9. _____ _____ _____ Ext_____
Day/Home Phone Number — Cell Phone Number — Work Number

10. The best number to contact you: ☐ Cell ☐ Day/Home ☐ Work ☐ Other _____ **11.** The best time to call _____ ☐ AM ☐ PM

12. What is your primary language? _____ **13.** Can we leave a message? ☐ Yes ☐ No

14. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced **15.** Your Religious Preference: _____

16. Are you a student? ☐ Yes ☐ No **17.** Are you a smoker? ☐ Yes ☐ No **18.** Are you currently homeless? ☐ Yes ☐ No

Tribal Affiliation

19. _____ _____ _____ _____
Tribe of Membership — Enrollment Number — Degree of Blood — Other Tribe

20. _____ _____
Father's Full Name — City and State of Birth

21. _____ _____
Mother's Full Maiden Name — City and State of Birth

Employment Information

22. _____ _____ _____ _____ _____ ☐ Full Time ☐ Part Time
Employer Name — Address — City — State — Zip Code

23. _____ _____ _____ _____ _____ ☐ Full Time ☐ Part Time
Spouse's Employer Name — Address — City — State — Zip Code

24. _____ **25.** _____ **26.** $_____ **27.** Are you a Migrant or Seasonal Farm Worker? ☐ Yes ☐ No
Spouse's Work Number — Total Household Members — Monthly Household (Gross) Income

Emergency Contact Information

28. _____ _____ _____
Emergency Contact Name — Relationship — Telephone Number

Please Complete Reverse Side

Insurance Information

29. Do you have Medicare or Railroad Retirement? ☐ Yes ☐ No _____
Policy Number

_____ _____ _____
Part A Date Part B Date Part D Date

30. Do you have the Oregon Health Plan or Medicaid? ☐ Yes ☐ No _____ _____
Recipient ID Number Eligibility Date

31. Do you have Insurance through your or anyone else's employer, or other source? ☐ Yes ☐ No

_____ _____ _____
Policy Number Name of Policy Holder Policy Holder's Date of Birth

_____ _____ _____ _____
Relationship to Holder Employer Group Name Policy Effective date Group Number

_____ _____ _____
Insurance Company's Name Address City

_____ _____ _____
State Zip Code Phone Number

32. List any other household members who are also covered by this insurance policy:

_____

_____

Veterans Information

33. Are you a veteran? ☐ Yes ☐ No Branch:_____ Entry Date:_____ Separation Date:_____

34. Did you serve in Vietnam? ☐ Yes ☐ No **35.** Do you have a serious disability? ☐ Yes ☐ No Claim Number:_____

36. Do you receive Veteran's health benefits? ☐ Yes ☐ No

List Other Dependant Household Members

Full Legal Name	Relationship	Sex	Date of Birth	Social Security Number

The information provided on this application is protected under the Privacy Act of 1974. I certify that this information is accurate and true to the best of my knowledge and I authorize Klamath Tribal Health & Family Services to verify its accuracy. I understand that under federal law, I have a responsibility to apply for and maintain any Alternate Resources that I qualify to receive and that failure to comply can result in the loss of access to and payment for health services.

Signature (Parent or Guardian if Minor):_____ Date:_____