

# KACHINA FAMILY PRACTICE REGISTRATION FORM

Please print

Today's Date  Dr's Name

## Patient's Information

Last Name  First Name  MI

Birth Date  Sex:  Male  Female SS Number

### Race

White  Asian  Black/African American  Native Hawaiian/Pacific Islander  American Indian/Alaskan Native  Declined to report

### Ethnicity

Not Hispanic/Latino  Hispanic/Latino  Declined to report

### Marital Status

Single  Married  Separated  Divorced  Widowed  Partnered

**Preferred Language**  English  Spanish  Other:   Declined to report

**Preferred Method of Communication**  Telephone, at this number:   Online via WebView

Address  Apt#

City  State  Zip Code

Home Phone  Work Phone  ext.

Cell Phone  Email Address

Employer's Name  Occupation

## Guarantor Information

(primary card holder on insurance)

Last Name  First Name  MI

Birth Date  Sex:  Male  Female SS Number

Address  Apt#

City  State  Zip Code

Home Phone  Work Phone  ext.

Cell Phone  Email Address

Employer's Name

## Emergency Contact for Patient

Name  Phone