KACHINA FAMILY PRACTICE
REGISTRATION FORM
PLEASE PRINT

PATIENT INFORMATION

Name:
Last First MI

Address: City: St: Zip:

Home Phone: ( )	Cell Phone: ( )	Email:
S.S.N.: - -	Birthdate: / /	Sex: ☐ Male ☐ Female

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Preferred Language:
☐ English ☐ Spanish ☐ Other

Race: ☐ White ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

Ethnicity:
☐ Hispanic/Latino ☐ Not Hispanic/Latino

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:

Subscriber Name:
Last First MI

S.S.N.: - -	Sex: ☐ Male ☐ Female	Relationship to Patient:	Birthdate: / /

SECONDARY INSURANCE NAME:

Subscriber Name:
Last First MI

S.S.N.: - -	Sex: ☐ Male ☐ Female	Relationship to Patient:	Birthdate: / /

EMPLOYMENT INFORMATION

Employer Name:	Employer Phone: ( )		
Address:	City:	St:	Zip:

EMERGENCY INFORMATION

Name:	Relationship to Patient:
Phone Number: ( )	Alternate Phone Number: ( )

RELEASE OF BENEFITS AND INFORMATION

I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process my claim. I authorize payment of insurance benefits to my physician for all services rendered. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care.

PLEASE PROVIDE INSURANCE CARDS AND PICTURE ID TO FRONT DESK TO BE SCANNED

Signature:	Date:
Parent (if minor):	Date: