K'ima:w Medical Center

An Entity of the Hoopa Valley Tribe

NEW PATIENT REGISTRATION FORM

Last Name:_____ First Name_____ Middle_____

Suffix: JR / SR / I / II / III Date of Birth:_____ Social Security Number:_____

CHART #:_____ Primary Language:_____ Sex: M / F

Marital Status:_____ Ethnicity: Declined to Answer / Hispanic or Latino / Not Hispanic or Latino / Unknown

Race:_____ Location of Home: _____

Classification/Beneficiary:_____ Eligibility Status:_____

Indian Blood Quantum:_____ Name of Tribal Membership:_____

Tribe Quantum:_____ Tribal Enrollment Number: _____

Mailing Address:_____ City:_____ State:_____ Zip Code:_____

Present Community:_____ Date Moved: _____

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____ Place of Birth: _____ State:____

Employment Status:_____ Employer:_____

Religious Preference: _____ Interpreter Required? YES / NO

Are you able to access the Internet? YES / NO If Yes, where? _____

E-mail address: _____

Do we have permission to send generic health information to your email address? YES / NO

Preferred method of communication? (Please circle one) E-Mail Letter Phone

Emergency Contact:

Last Name:_____First Name: _____Relationship: _____

Address:_____ City: _____ State: _____ Zip Code:_____

Phone Number: ( ) _____ - _____ Work Phone: ( ) _____ - _____

Family Information:

Father's Name:_____ City/State of Birth: _____

Father's Employer and Address:_____

Father's Phone: ( ) _____ - _____