Klamath Tribal Health & Family Services

Patient Registration Update Form

Please **PRINT** in **Legible Handwriting**

KTHFS Use Only
❑ Yes ❑ No Alt Resource Check:
Chart Number

Patient Information

1. _____ **Full Legal Name**
2. _____ **Date of Birth**
3. _____ **Social Security Number**

4. _____ **Mailing Address** _____ **City** _____ **State** _____ **Zip Code**

5. _____ **Physical Address (*If Different from Mailing Address*)** _____ **City** _____ **State** _____ **Zip Code**

6. _____ **Day/Home Phone Number** _____ **Cell Phone Number** ***Email Address:*** _____

7. What is your primary phone number? ☐ **Cell** ☐ **Day/Home** ☐ **Work** **8.** Are you a Full-Time Student? ☐ Yes ☐ No 9. Are you a smoker? ☐ Yes ☐ No

10. Are you currently homeless? ☐ Yes ☐ No **11.**Are you: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Employment Information

12. _____ Employer Name _____ Address / City / State / Zip Code _____ Start Date

_____ Work Number ☐ Full Time ☐ Part Time ☐ Seasonal _____ Total Household Members $_____ Monthly Household (Gross) Income

Emergency Contact Information

13. _____ Emergency Contact Name _____ Relationship _____ Address / City / State _____ Phone Number

Insurance Information

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

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

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

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

_____ Insurance Company's Name _____ Policy / ID Number _____ Employer Group Name

_____ Employer Group Number _____ Effective date Coverage Includes: ☐ **Medical** ☐ **Dental** ☐ **Pharmacy** ☐ **Vision**

_____ Name of Policy Holder _____ Relationship to Holder _____ Policy Holder's Date of Birth

_____ Insurance Company's Address / City / State / Zip Code _____ Insurance Company's Phone 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:**_____