MOLOKAI COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM

TODAY'S DATE: _____

NAME: _____
Last Name First Name MI Preferred

GENDER: [ ] Male [ ] Female **DOB:** _____ **EMAIL:** _____

MAILING ADDRESS: _____
Street/PO Box City State Zip Country

PHYSICAL ADDRESS: _____
(if different) Street City State Zip Country

HOME PHONE: _____ [ ] Ok to Call **MOBILE PHONE:** _____ [ ] Ok to Call [ ] Ok to Text

---

LANGUAGE: _____ **MARITAL STATUS:** [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Partner

RACE: [ ] American Indian/Alaskan Native [ ] Asian [ ] Black/African American [ ] Native Hawaiian [ ] Other Pacific Islander [ ] White
(Check all that Apply) [ ] Decline

ETHNICITY: [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Unknown [ ] Decline

SEXUAL ORIENTATION: [ ] Lesbian or Gay [ ] Straight [ ] Bisexual [ ] Unknown [ ] Something else _____ [ ] Decline

GENDER IDENTITY: [ ] Male [ ] Female [ ] Transgender Male [ ] Transgender Female [ ] Non-Conforming [ ] Additional Gender [ ] Decline

---

FAMILY SIZE: _____ [ ] Decline **INCOME:** $_____ [ ] Year [ ] Month [ ] 2 Weeks [ ] Week [ ] Decline

AGRICULTURAL WORKER: [ ] Yes [ ] No **HOMELESS:** [ ] Yes [ ] No **VETERAN:** [ ] Yes [ ] No **PUBLIC HOUSING:** [ ] Yes [ ] No

---

EMERGENCY CONTACT: _____ **RELATION:** _____

HOME PHONE: _____ [ ] Ok to Call **MOBILE PHONE:** _____ [ ] Ok to Call [ ] Ok to Text

If patient is a minor, please provide the information below.

FATHER'S NAME: _____ **DOB:** _____

MOTHER'S NAME: _____ **DOB:** _____

GUARDIANS NAME: _____ **DOB:** _____

MEDICAL INSURANCE

PRIMARY INSURANCE: _____

INSURANCE ID #: _____

SUBSCRIBER: _____

SECONDARY INSURANCE: _____

INSURANCE ID #: _____

SUBSCRIBER: _____

DENTAL INSURANCE

PRIMARY INSURANCE: _____

INSURANCE ID #: _____

SUBSCRIBER: _____

SECONDARY INSURANCE: _____

INSURANCE ID #: _____

SUBSCRIBER: _____