KENNEDY HEALTH ALLIANCE™

Patient Registration Form

Patient Last Name: _____
First Name: _____ MI: ____
Address: _____
City, State, Zip: _____
Marital Status: ☐Single ☐Married ☐Widowed
☐Separated ☐Divorced ☐Other: _____
Primary Language: ☐Eng ☐Spa ☐Other: _____
Home Phone: _____
Cell Phone: _____
Email: _____

Social Security Number: _____
Date of Birth: _____ Sex: ☐M ☐F
Race:
☐American Indian or Alaska Native
☐Native Hawaiian/Pacific Islander
☐Black or African American ☐White
☐Asian ☐Patient declined
Ethnicity: ☐Hispanic or Latino
☐ Not Hispanic or Latino
☐ Patient Declined

Best way to contact you: ☐Home Phone ☐Cell Phone ☐ Email ☐ Other: _____

How did you hear about us: ☐ Family/Friend ☐Insurance ☐ Website ☐ Social Media
☐ Advertisement ☐Other: _____

Employment Status: ☐Full Time ☐Part Time ☐Self Employed ☐ Retired ☐Unemployed
☐ Student ☐ Active Military
Employer: _____
Address: _____ City, State, Zip: _____
Work Phone: _____

Emergency Contact
Last Name: _____ MI: _____ Address: _____
First Name: _____ City, State, Zip: _____
Relation: _____ Primary Phone: _____

Insurance Information (Please give cards to patient service representative)
Primary Insurance: _____
Secondary Insurance: _____
☐No Insurance: Self pay

Holder of Insurance
Last Name: _____
First Name: _____ MI: _____
Date of Birth: _____ Social Security Number: _____
Primary Phone: _____ Sex: ☐M ☐F
Relation: _____

Local Pharmacy
Name: _____
Address: _____
City, State, Zip: _____

Mail Away Pharmacy
Name: _____
Address: _____
City, State, Zip: _____

Patient Signature: _____ Date: _____