KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

PATIENT INFORMATION REGISTRATION
FORM: Complete all sections

Please check all services that are requesting:

☐ **Dental** ☐ **Behavioral Health** ☐ **Primary Medical Care**

PATIENT INFORMATION:

Last name	First Name	MI	Preferred Name	Social Security #	Birthdate	Birth Sex

BILLING ADDRESS of Patient or Responsibility Party	City	State	Zip

MAILING ADDRESS	City	State	Zip

Phone ( )	Alternate Phone ( )	Email address:

We utilize phone calls, texting and email for appointment reminders. A written request will be necessary if you do not want to receive one of the above.

How did you hear about us? ◉ Patient ○ Newspaper ○ Internet ○ Radio ○ Flyer ○ Billboard ○ Community Event ○ Other_____

Emergency Contact

Last Name	First Name
Relationship to Patient	Emergency Contact Phone Number:

INFORMATION FOR STATISTICAL REPORTING ONLY: Please ✓ all that applies:

Race: ○ White ○ Black/African American ○ Asian ○ Asian Indian ◉ American Indian/Alaska Native ○ Native Hawaiian ○ Other ○ Pacific ○ Chinese ○ Filipino ○ Guamanian/Chamorro ○ Japanese ○ Korean ○ Vietnamese ○ Samoan ○ Asian Indian ○ Other Asian ○ More than one Race ○ Other (Please specify)_____ ○ Refused to answer

Ethnicity ○ Not Latino/Hispanic or another Spanish orign ○ Mexican, Mexican American, Chicano/a ○ Cuban ○ Puerto Rican ○ Another Hispanic, latino/a, or Spanish orign ○ Refuse to Answer

Preferred language: ◉ English ○ Spanish ○ French ○ Sign Language ○ German ○ Russian ○ Other:_____

Marital Status: ○ Single ○ Married ○ Widowed ○ Legally Septerated ○ Divorced ○ Life Partner ○

Occupation: What is your current work situation? ◉ Unemployed ○ Part-Time or temporary work ○ Full-time employment ○ Otherwise, unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:_____ ○ I choose not to answer this question.

Are you a Veteran? ○ Yes ○ No Are you a Migrate Worker? ○ Yes ○ No ○ Seasonal
Are you homeless? ○ Yes ○ No If yes, where are you living? ○ Shelter ○ Transitional ○ Doubling Up ○ Street ○ Other

What **Advanced Directives** do you have: ◉ Living Will ○ Durable Power of Attorney ○ Health Care Proxy ○ None ○ Decline to answer ○ Legal Guardian
If Yes, please specify who & their relation to you and proivide a copy of document:_____

Created 05/2024

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PATIENT INFORMATION REGISTRATION
FORM: Complete all sections

For Patients 16 and Older ONLY
Sexual Orientation: ○ Straight or Heterosexual ○ Lesbian, Gay or Homosexual ○ Bisexual
○ Something else (please specify):_____ Don't Know Decline to answer

For Patients 16 and Older ONLY
Gender at Birth: ◉ Male ○ Female ○ Other:_____

Current Gender Identity: Do you think of yourself as: ○ Male ○ Female ○ Transgender (please specify): Female-to-Male or Male-to-Female ○ Genderqueer, neither exclusively male nor female

○ Other/Additional gender category_____ ○ Decline to Answer

I understand that it is my responsibility to provide complete and accurate information on this form. I understand that failure to provide this information may result in my being responsible for full charges.

_____ _____ _____

Patient Name (Printed) Signature of Patient/Responsible Party Date

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