

 IFHC

 PATIENT REGISTRATION

**PRIMARY LANGUAGE SPOKEN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OTHER LANGUAGE(S) SPOKEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Interpreter Required? Yes No**

**Are you currently homeless? No Yes (If yes, please provide the following information as to where you are presiding):**

 **Homeless Shelter Doubling Up Other Transitional Facility**

 **Streets Unknown**

***I understand the information given by me and/or collected is necessary for the Indian Family Health Clinic to provide services for my health care and well-being, furthermore; I have been informed that my health records shall not be disclosed to any other agency or person. I certify the information given in this application for medical services provided at the Indian Family Health Clinic is true and accurate to the best of my knowledge.***

**Patient/Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Month/Day/Year**

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CONFIDENTIAL

IFHC HEALTH CLINIC FORM FY23