Kansas Medical Clinic

Patient Information

In order to serve you properly, we need the following information. All information is strictly confidential.

Patient Name (Last, First, MI)	Sex □ Male □ Female	Birthdate (MM/DD/YY)	Marital Status □ Single □ Divorced □ Married □ Widowed
Address	City	State	Zip
Email Address	Home Phone	Cell Phone	
Employer	Social Security Number		

Employment Status □ Full Time □ Part Time □ Unemployed □ Self	Student Status □ Full Time □ Part Time	**Responsible Party** □ Self (If not self, provide name, DOB & Relationship) Name/DOB	Relationship
Emergency Contact Name and Relationship	Home Address □ Same as Patient or complete below Preferred Phone: Alternate Phone:		
Insurance Subscriber Name	Patient Work Number		□ Spouse □ Parent □ Guardian □ Other
Subscriber Address	Subscriber DOB (MM/DD/YY)	Subscriber SSN	
Insurance Subscriber Name #2			□ Spouse □ Parent □ Guardian □ Other
Subscriber Address	Subscriber DOB (MM/DD/YY)	Subscriber SSN	

Race: □American Indian/Alaska Native □Asian □Black/African Am. □Pacific Islander □Hispanic □White □Prefer not to answer

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Prefer not to answer

Preferred Language: □ English □ Spanish □ Indian □ Russian Other (Specify)_____

How did you hear about us?

Preferred Pharmacy:

Primary Care Provider:	Referring Physician:

Authorization To Release Information and Assignment of Insurance Benefits

I acknowledge that all the information I have provided to Kansas Medical Clinic (KMC) is accurate and correct. I request payment of authorized Medicare/Insurance benefits to me, or on my behalf, for any services furnished to me by KMC including physician services. I authorize any holder of medical and other information about me to release to Medicare/Insurance and its agents any information needed to determine these benefits for related services. I understand that I am responsible for any and all balances owed regardless of insurance.

Patient's Signature: _____ Date: _____

Signed by: _____ Relationship: _____