Heart of Kansas Family Health Care, Inc.
"We Care about your Health"

Registration Information

Please Print

Patient's Legal Name _____
Last *First* *Middle Initial*

Date of Birth ___/___/_____ **Social Security #**_____ **Sex** M F

Is patient a Child? YES or NO **(If no, skip to patient address)**

Is patient in Foster Care, Juvenile Intake, DCF, SRS or state custody? YES or NO

Complete parent information if patient is your natural/biological/adopted child. If this is not your natural/biological/adopted child, please notify the front desk staff.

Parent Information:

Mother's Name (Legal Parent)	**Father's Name** (legal parent)
Address:	**Address:**
City/State:	**City/State:**
Phone #	**Phone #**

Patient's Address _____ **City**_____ **State** ____ **Zip** _____

Best Phone to reach patient: _____ **Alternate phone#:** _____

Email address_____

Marital Status: Child/Student Single Married Divorced Remarried Living together

Employment Status (circle): Full time Part time Retired Not employed

Race: (circle all that apply) •American Indian/Alaska Native •Asian •White •Black/African American •Native Hawaiian •Other Pacific Islander

Ethnicity: •Hispanic/Latino •Non-Hispanic/Latino

Are you a veteran? (Have you ever served in the US military?) Yes No

Agricultural status (circle): •Nonagricultural worker •Seasonal worker (farmworker) Migrant worker Dependent of seasonal worker (farmworker) • •Dependent of migrant worker

Are you homeless? YES or NO **Do you require interpreter services?** YES or NO

Insurance Company Name: _____

Policy Holder Name _____ **Policy #** _____

Group # _____

Please have your insurance card available for us to copy

Person responsible for the bill:

Name: _____ **SS#** _____

Date of Birth _____ **Gender:** M F

Address _____ **City:**_____ **State** ____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Employer Name: _____ **Employer Phone:** _____

Why is this person responsible? _____

Emergency contact Information:

Emergency contact name _____ **Phone#** _____

Certification: I certify that the information given in this form is true and accurate. This may be verified.

*If you wish to apply for reduced fees, you are required to present all sources of income including wages, unemployment, social security, worker's comp, SSI, SRS, child support, veteran's benefits, alimony, food stamps, savings and any resources available to the patient/family.

_____ _____

Signature of Patient **Date** **Signature of Parent if minor** **Date**

For Office use Only

_____

Relationship to Minor Patient