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)	Birth Sex ☐Male ☐Female	Birthdate: (MM/DD/YY)	Marita; Status ☐ Single ☐Divorce ☐ Married ☐ Widowed

Sexual Orientation: ☐ Lesbian, gay, homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Do not know ☐ Choose not to disclose. ☐ Other _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Female-to-Male transgender ☐ Male-to-Female transgender ☐Genderqueer ☐ Choose not to disclose. ☐Other _____

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	Preferred Phone: Alternate Phone:

Insurance Subscriber Name	Subscribe DOB (MM/DD/YY)	Subscriber SSN	☐ Spouse ☐Parent ☐Guardian ☐Other
Secondary Insurance Subscriber Name	Subscribe DOB (MM/DD/YY)	Subscriber SSN	☐ Spouse ☐Parent ☐Guardian ☐Other

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:
Do you have an advanced directive	☐ DNR ☐ YES ☐ NO

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: _____

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