Community Health Center of Southeast Kansas

Thank you for choosing CHC/SEK for your health care needs. To help us meet your needs, please complete this form in ink. If you have any questions or need assistance, please ask the receptionist or call 620-231-9873.

PATIENT INFORMATION

Full Legal Name______________________________________ Wish to be called_________________________

Address_______________________________________City__________________State & Zip_______________

Date of Birth___________________ Social Security Number_______________________Male ❑ Female ❑

Phone Number_________________ Cell Phone________________ Work Phone_________________

E-Mail Address________________________________

PERSONAL INFORMATION

- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widowed
- ❑ Separated
- ❑ Life Partner
- ❑ Legally Separated

- ❑ Full-time Student
- ❑ Part-time Student
- ❑ Not in School

- ❑ Full-time Employment
- ❑ Part-time Employment
- ❑ Unemployed

- ❑ American Indian/Alaskan
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian
- ❑ Other Pacific Islander
- ❑ White
- ❑ Refuse to report
- ❑Other______________

Employer_________________________Occupation_____________________

❑Hispanic/Latino
❑Not Hispanic/Latino

Housing Status: ❑ Doubling Up ❑Homeless Shelter ❑Not Homeless ❑Other ❑Street ❑Transitional

Have you or has anyone in your household worked in agriculture, such as planting, cultivating, or harvesting agriculture products (fruits, vegetables, grains, or dairy) in the last 2 years? Yes ❑ No ❑

Are you a veteran? Yes ❑ No ❑

Do you need an interpreter? Yes ❑ No ❑ If yes, what language?_________________________________

Please complete back of form

RESPONSIBLE PARTY

Name______________________________Street Address____
City, State, Zip____
Relationship to Patient____________________Birth Date_________________Social Security #________________

EMERGENCY CONTACT

In the event of an emergency, who should we contact? ____

Relationship?_______________ Home #________________ Cell #_______________ Work #_________________

INSURANCE INFORMATION

____ No Health Insurance
____ No Health Insurance but currently working or have worked in agriculture/farm work in the last 2 years.
____ Kansas Medicaid or KanCare (Amerigroup, Sunflower, United HealthCare)
Card # ____________________________
____ Other Medicaid
Card #____________________________ State ____________________
____ Medicare Part A______ Part B_____ ID Number_________________ Effective Date_____
____ Medicare Supplement
____ Private Health Insurance

Primary Insurance	**Secondary Insurance**
Insurance Policy Name_________________________	Insurance Policy Name _________________________
Name of Insured_______________________________	Name of Insured ______________________________
Relationship to Patient________________________	Relationship to Patient ________________________
Group Number_______________________________	Group Number _______________________________
Member ID Number ___________________________	Member ID Number ___________________________
Insured's Date of Birth ________________________	Insured's Date of Birth ________________________
Social Security Number________________________	Social Security Number________________________
Employer___________________________________	Employer___________________________________
Date Employed ______________________________	Date Employed ______________________________
Occupation _________________________________	Occupation _________________________________

Please provide a copy of your insurance card for billing purposes.

Thank you for using health care services provided by CHC/SEK. Please note that all information provided by you will be kept strictly confidential in compliance with Federal privacy laws.

Effective 2/5/2013