Community Health Center of Southeast Kansas

Thank you for choosing CHC/SEK for your healthcare needs. Please note that all information provided by you will be kept strictly confidential in compliance with Federal privacy laws. If you have any questions or need assistance, please ask the receptionist or call 620-231-9873. *Please complete this form in ink.*

PATIENT INFORMATION

Full Legal Name

Last Name:	First:	Middle:

Mailing Address_____ City _____

State & Zip_____

Home Number_____ Cell Phone_____ Work Phone_____

Preferred method of communication for appointment reminders: ❑ Text ❑ Phone Call

Date of Birth_____ Male❑ Female ❑ Social Security Number_____

Marital Status:
❑Divorced
❑Married
❑Partner
❑Single
❑Widowed
❑Legally Separated

Employment Status:
❑Full-time Employment
❑Part-time Employment
❑Unemployed
❑Self-Employed
❑Retired

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

RESPONSIBLE CAREGIVER (Children under 18 years of age OR Adults with Durable Power of Attorney)

Name_____Mailing 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 #_____

Please Complete the Back of Form

INSURANCE INFORMATION

Check all that apply:

❑No Health Insurance

Would you like to meet with a patient navigator to see if you are eligible for Medicare Part D, Medicaid or Insurance Market place? Yes ❑ No ❑

❑KanCare (Amerigroup, Sunflower, United HealthCare)

❑Other Medicaid (Oklahoma or Missouri)

❑Medicare ❑Medicare Supplement

❑Motor Vehicle Accident ❑Workers Compensation

❑Commercial Insurance ❑Other Accident

Provide insurance information below.

Please provide the front desk your insurance card for billing purposes.

Primary Insurance	**Secondary Insurance**
Insurance Plan_____	Insurance Plan_____
Member ID Number _____	Member ID Number _____
Group Number _____	Group Number _____
Policy Holder Information:	**Policy Holder Information:**
Full Name _____	Full Name _____
Date of Birth _____	Date of Birth _____
Social Security Number _____	Social Security Number _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____

E-Mail Address_____

Race:

❑American Indian/Alaskan

❑Asian

❑Native Hawaiian

❑Black or African American

❑White

❑Hispanic

❑Other Race

❑Pacific Islander

Ethnicity:

❑Hispanic/Latino

❑Not Hispanic/Latino

Preferred Language

❑English

❑Spanish

❑Other _____

Veteran:

❑Yes

❑No

If you are Homeless, are you:

❑On the Street

❑Doubling Up

❑In Transitional Housing

❑In a Shelter

❑Other

Have you or has anyone in your household worked in agriculture, such as planting, cultivating, or harvesting (fruits, vegetables, grains, or dairy) in the last 2 years as a:

❑Seasonal Worker

❑Migrant Worker

Pharmacy:_____ _____

Name City & State

**Apothecare, located near the main entrance, is CHCSEK's preferred pharmacy.