**Community Health Center of Southeast Kansas**

Thank you for choosing Community Health Center of Southeast Kansas, Inc. (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 (Print)

| Last Name: | First Name: | Middle Name: |
|---|---|---|
| | | |

Mailing Address_____ City _____

State_____ Zip Code_____ E-Mail Address_____

Do you want to access your medical records electronically? ❑Yes ❑No
(If yes, you will receive an email, at the email address listed above, from CHC/SEK with your log-in information and the log-in URL.)

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:** | **Employment Status:** | **Student Status:** |
|---|---|---|
| ❑Divorced | ❑Active Duty Military | ❑Full-time Student |
| ❑Married | ❑Full-time Employment | ❑Part-time Student |
| ❑Partner | ❑Part-time Employment | ❑Not in School |
| ❑Single | ❑Self-Employed | |
| ❑Widowed | ❑Retired | |
| ❑Legally Separated | ❑Unemployed | |

**RESPONSIBLE CAREGIVER (**Children under 18 years of age OR Adults with Durable Power of Attorney)
(Children under 18 years of age, please list two Responsible Caregivers)

| | |
|---|---|
| Name:_____ | Name:_____ |
| Date of Birth: _____ | Date of Birth: _____ |
| Social Security Number: _____ | Social Security Number: _____ |
| Relationship to the Patient:_____ | Relationship to the Patient:_____ |
| Mailing Address: _____ | Mailing Address: _____ |
| City, State, Zip: _____ | City, State, Zip: _____ |

(If Responsible Caregiver(s) is a foster parent or out-of-home placement, immediately produce appropriate paperwork illustrating placement and appropriate paperwork illustrating who maintains authority to make medical decisions on the patient's behalf).

**Please Complete the Back of Form**

## EMERGENCY CONTACT

In the event of an emergency, who should we contact? _____
Relationship?_____
Home Number _____ Cell Phone_____ Work Phone _____

## INSURANCE INFORMATION

**Check all that apply:**

❑No Health Insurance (Patient navigators are available to help determine if you are eligible for medical discounts or coverage)

❑KanCare (Amerigroup, Sunflower, United HealthCare) ❑Commercial Insurance
❑Other Medicaid ❑Medicare ❑Medicare Supplement
❑Motor Vehicle Accident ❑Workers Compensation ❑Other Accident

**Provide insurance information below. Please provide the front desk with 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 _____ |

## FINANCIAL INFORMATION (Please fill-out to help determine if you are eligible for medical discounts)

Persons In Family/Household: ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑Other_____
Estimated Annual Family/Household Income:_____

**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 two (2) years as a:

❑Not Applicable ❑Seasonal Worker ❑Migrant Worker

**Pharmacy:**_____ _____
Name City & State

**Apothecare, physically located inside CHC/SEK's Pittsburg and Iola clinics, is CHCSEK's preferred pharmacy.