PATIENT INFORMATION **MUST BE FILLED OUT COMPLETELY**

Patient's Name: _____ ☐ Male ☐ Female
last first m.i. D.O.B Sex

Name and birthdate of other children seen in our office(s) _____

Patient's Address: _____
street # apt #/ lot #

_____
city state zip Patient's Social Security #

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline Preferred language: ☐ English ☐ Spanish ☐ Other

E-Mail for Lab Results and Statements: _____

Pt's Dr at M.K.P.A.: ☐ Hund ☐ Kinnane ☐ Haynes ☐ Stucky ☐ Crosse ☐ Weiser ☐ Bowen ☐ Gherardini Location Preference: _____

PARENT INFORMATION

Father's Name: _____
last first m.i. D.O.B

Father's Address _____
street # apt #/ lot # S.S. #

_____ Main
city state zip Phone # _____

Relationship to patient: ☐ Father ☐ Stepfather ☐ Other _____ Alternate
Phone # _____

Spouse: _____ Father's Employer: _____ Work # _____

Mother's Name: _____
last first m.i. D.O.B

Mother's Address: _____
street # apt #/ lot # S.S. #

_____ Main
city state zip Phone # _____

Relationship to patient: ☐ Mother ☐ Stepmother ☐ Other _____ Alternate
Phone # _____

Spouse: _____ Mother's Employer: _____ Work # _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Effective Date: _____

Policy Number _____ Group Number _____ Copay _____

Name of Policy Holder (employee): _____ DOB_____

Relationship to patient: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Other_____

Secondary Insurance Co. _____ Effective Date: _____

Policy Number _____ Group Number _____ Copay _____

Name of Policy Holder (employee): _____ DOB_____

Relationship to patient: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Other_____

I do hereby authorize the release of any medical information to process the medical claims and request payment of any medical benefits to be made to Mid-Kansas Pediatric Associates, P.A. I understand that any services not covered or paid by my insurance company will be my responsibility.

Signed: **X**_____ Date: _____