PATIENT INFORMATION **MUST BE FILLED OUT COMPLETELY**

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

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

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

_____ _____
city state zip Patient's Social Security Number

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: _____

Patient's Dr. at M.K.P.A.: ☐ Kinnane ☐ Haynes ☐ Stucky ☐ Crosse ☐ Bowen ☐ Vincent ☐ Gherardini ☐ Peller ☐ Montgomery

PARENT INFORMATION

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

Parent's Address: _____ _____
street # apt # / lot # Social Security Number

_____
city state zip

Relationship to Patient: _____ **Spouse**: _____ **Employer**: _____

Check Preferred Phone Number: ☐Home_____ ☐Cell _____ ☐Work _____

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

Parent's Address: _____ _____
street # apt # / lot # Social Security Number

_____
city state zip

Relationship to Patient: _____ **Spouse**: _____ **Employer**: _____

Check Preferred Phone Number: ☐Home_____ ☐Cell _____ ☐Work _____

INSURANCE INFORMATION

Primary Insurance Co. _____ **Effective Date:** _____

Policy Number: _____**Group Number** _____ **Co-pay** _____

Name of Policy Holder (employee) _____ **D.O.B.** _____

Relationship to Patient: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Other _____

Secondary Insurance Co. _____ **Effective Date:** _____

Policy Number: _____**Group Number** _____ **Co-pay** _____

Name of Policy Holder (employee) _____ **D.O.B.** _____

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:** _____