Patient Information

Patient Name:

Address: City: State: Zip Code:

Telephone: ( ) Email address:

Date of Birth: Age: Sex:

Race: Ethnicity: Preferred language:

If someone calls or visits, is it okay to let them know you are here? ☐ Yes ☐ No

Social Security: Marital Status:

Patient Employer Information

Employer Name: Employer Phone:

Employer Address: City: State:

If Self-Employed, Name of Business:

Spouse Information

Name: Date of Birth: Age:

Social Security: Employer Name:

Employer Address:

If Self-Employed, Name of Business:

Insurance Information

Name of Insurance Company:

Insurance Address:

Insured's Name: Relationship to Patient:

Policy Number: ID Number: Group Number:

Medicare Number:

General Information

Family Physician's Name:

Have you been a patient here before: ☐ Yes ☐ No If so, under what name?

Relative

Nearest relative NOT living with you:

Relationship: Phone Number:

Please scan and email this form along with your driver's license and insurance card(s) to lois_borkholder@kch.com.

Thank you!