

MCPHERSON COUNTY HEALTH DEPARTMENT

1001 N. Main St., McPherson, KS
620-241-1753

CLIENT REGISTRATION FORM

CLIENT # _____ SOCIAL SECURITY # _____

CLIENT'S LEGAL NAME _____

OTHER NAMES YOU MAY BE KNOWN AS _____

BIRTHDATE _____ AGE _____ SEX _____ MARITAL STATUS _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE(_____) _____ CELL PHONE(_____) _____ WORK PHONE(_____) _____

CLIENT'S EMPLOYER & ADDRESS _____

CLIENTS PRIMARY CARE PHYSICIAN NAME, PHONE # & ADDRESS _____

BILLING INFORMATION

(IF CLIENT IS A MINOR CHILD, PLEASE COMPLETE BELOW)

FATHER'S FULL NAME _____ D.O.B. _____ SOCIAL SECURITY# _____

ADDRESS _____

EMPLOYER _____ HOME# _____ WK # _____

MOTHER'S FULL NAME _____ D.O.B. _____ SOCIAL SECURITY # _____

ADDRESS _____

EMPLOYER _____ HOME# _____ WK# _____

FULL NAME OF **OTHER** PERSON RESPONSIBLE FOR PAYMENT (IF OTHER THAN PATIENT): _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTH DATE _____ AGE _____ SOCIAL SECURITY # _____

HOME PHONE (_____) _____ CELL PHONE (_____) _____ WORK PHONE (_____) _____

NO INSURANCE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____ EFFECTIVE DATE _____

POLICY HOLDERS NAME _____ BIRTHDATE _____ EMPLOYER _____

ID/POLICY # _____ GROUP # _____

IS THERE OTHER INSURANCE COVERAGE? (INCLUDE DETAILS, IF YES): _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MCPHERSON COUNTY HEALTH DEPARTMENT AND AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT OF EXPENSES NOT COVERED BY MY INSURANCE.

AUTHORIZED SIGNATURE _____ DATE _____

TO THE BEST OF MY KNOWLEDGE THE INFORMATION ABOVE IS TRUE AND CORRECT. (INITIALS OF PERSON COMPLETING FORM & DATE) _____

I HAVE BEEN OFFERED A COPY OF THE MCPHERSON COUNTY HEALTH DEPARTMENT'S NOTICE OF PRIVACY PRACTICES.

AUTHORIZED SIGNATURE _____ DATE _____

RELATIONSHIP TO CLIENT _____