



KANSAS MEDICAL CLINIC PA

Referring Provider: _____

Account Number: _____

Primary Care Provider: _____

Patient Information

Name _____
Last Name First Name Middle Initial Preferred Name (nickname)

Sex: Male Female Date of Birth: _____ Age: _____

Social Security Number _____ Marital Status: Married Single Widowed Divorced Separated

Home Address: _____
Street City/Town State Zip Code

Home Phone: (____) _____ Business Phone: (____) _____

Cell Phone: (____) _____ Email: _____

Employer Name: _____

Business Address: _____

Primary-Insurance Policy Holder Information: Please give insurance card to receptionist

Insurance Company: _____ Policy ID: _____ Group No: _____

Policy Holder Name: _____ SS#: _____
Last First MI

Date of Birth: _____ Sex: Male Female Relationship to patient: Self Spouse Parent Other

Employer (Company Name): _____

Business Address: _____ Phone: _____

Please document insurance requirements for lab work/pathology: _____

Secondary-Insurance Policy Holder Information: Please give insurance card to receptionist

Insurance Company: _____ Policy ID: _____ Group No: _____

Policy Holder Name: _____ SS#: _____
Last First MI

Date of Birth: _____ Sex: Male Female Relationship to patient: Self Spouse Parent Other

Employer (Company Name): _____

Business Address: _____ Phone: _____

Authorization To Release Information and Assignment of Insurance Benefits

I acknowledge that all the information I have provided to Kansas Medical Clinic (KMC) is accurate and correct. I request payment of authorized Medicare/Insurance benefits to me, or on my behalf, for any services furnished to me by KMC including physician services. I authorize any holder of medical and other information about me to release to Medicare/Insurance and its agents any information needed to determine these benefits for related services. I understand that I am responsible for any and all balances owed regardless of insurance.

Patient's Signature: _____ Date: _____

Signed by: _____ Relationship: _____