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 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_____