1411 W. 4th Bldg C Coffeyville, KS 67337 Phone: 620-251-2400 Fax: 620-251-1619

Last Name ______________________ First Name ______________________ Initial ______

Home Phone ______________________ Work Phone ______________ Cell ______________

Address ____

City ______________________ State ______________ Zip code ______________

SSN ______________________ Birth date ______________ Gender ______________

Marital Status ______________________ Employer ______________________________

Emergency Contact ______________________ Relationship ______________________

Emergency Contact Phone ______________________________

How did you hear about our clinic? ______________________________

Insurance Information:

______________________	______________________	______________________
Primary Insurance Company	ID#	Group #
Insurance owner's name	SSN	D.O.B.

Insurance owner's address ______ City ______ State ______ Zip ______

______________________	______________________	______________________
Secondary Insurance Company	ID#	Group #
Insurance owner's name	SSN	D.O.B.

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"I authorize and request payment of medical benefits to the attending practitioner for the services rendered & I authorize the practitioner to furnish any information required for the processing of my claim. I am required to pay my co-pay, deductible, & coinsurance at the time of service."

Insured's signature ______________________________ Date ______________

"As a self pay patient, I understand that I am responsible to pay for services rendered at the time of my visit."

Private Pay Signature ______________________________ Date ______________

Signature ____

All patients must sign. HIPPA: I have received notice of the privacy practice from Southeast Kansas Health Care, LLC.