DEMO

NMC health

PO Box 308 | Newton, KS 67114

Patient Demographics

Patient Name: _____ Preferred Name: _____
(First) (MI) (Last) (Suffix)

Date of Birth: _____/_____/_____ Social Security Number: _____ Gender: M F

Home Address: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone: (_____) _____☐ Cell ☐ Home Alternate Phone: (_____)_____☐ Cell ☐ Home

Email: _____@_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Ethnicity: ☐Hispanic ☐Non-Hispanic

Race: ☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐Hispanic ☐ Native American ☐Other: _____

Preferred Language: ☐English ☐Spanish ☐Other: _____

Employer: _____ Work Phone: (_____) _____

Primary Care Physician/Provider (PCP): _____ Referring Physician/Provider: _____

PRIMARY HEALTH INSURANCE INFORMATION

Insurance company name: _____ Policy #: _____ Group #: _____

Insured name: _____ Insured SS# _____

Insured address: _____ Phone:_____

Insured date of birth: _____ Insured employer: _____

Employer address & phone: _____

SECONDARY HEALTH INSURANCE INFORMATION

Insurance company name: _____ Policy #: _____ Group #: _____

Insured name: _____ Insured SS# _____

Insured address: _____ Phone:_____

Insured date of birth: _____ Insured employer: _____

Employer address & phone: _____

Release of Information

By listing the following names, you are granting permission for us to share your information with them. (CHECK THE BOXES ON EACH PERSON FOR WHAT INFORMATION YOU WANT SHARED)

1) Name: _____ Relationship: _____Phone Number: (____) _____

Address: _____ City: _____ State: _____ Zip code_____

Information to share: ☐Appointments ☐Clinical ☐ Financial

2) Name: _____ Relationship: _____ Phone Number: (____) _____

Address: _____ City: _____ State: _____ Zip code_____

Information to share: ☐Appointments ☐Clinical ☐ Financial

☐ DO NOT SHARE ANY INFORMATION WITH ANY OTHER INDIVIDUAL EXCEPT PATIENT

_____ _____ _____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**

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