

Family Health Center

506 Thorpe Street
Lakin, Kansas 67860
(620) 355-7550 FAX: (620) 355-7500

521 Main
Deerfield, Kansas 67838
(620) 426-2990 FAX: (620) 426-2991

PATIENT REGISTRATION FORM (Please print all information)

Date: _____

Patient Information: (Provide Legal Name)

Male _____ Female _____

Name: _____
 Last First MI

Marital Status:

_____ Single

_____ Married-Spouse _____

_____ Other

Address: _____

Phone Number: _____

Employer: _____

Birth Date _____ Race: _____

Address _____

Social Security #: ____ - ____ - ____

Phone: _____

Accident information:

Date: _____ Work related: _____ Auto: _____ Other: _____

Responsible Party:(If different from patient)

Name: _____
 Last First MI

Employer: _____

Address _____

Address: _____

Phone: _____

Phone Number: _____

Birth Date _____ Race: _____

Social Security #: ____ - ____ - ____

Emergency Contact: (friend or relative not living with you)

Name: _____

Relationship: _____

Address: _____

Phone: _____

Insurance information: (We will need copies of your card(s))

Primary

Secondary

Name: _____

Name: _____

Policy Holder: _____

Policy Holder: _____

Birth Date: _____

Birth Date: _____

Consent for Treatment: I consent to x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, hospital services, and/or other services rendered under the general and special instructions of my attending or consulting physicians. I understand that my treatment is under the control of my attending physicians, their assistants or designees. I understand that the practice of medicine and surgery is not an exact science, and acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.

X _____ X _____
Parent/Guardian Signature Date

Insurance/Self Pay Patients: I hereby assign my insurance benefits otherwise payable to me to be paid directly to the Family Health Center. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payment of all charges not covered by third party payers. If I do not pay the amount due as I agreed, I agree also to pay the reasonable costs of collection, including but not limited to attorney fees and collection agency fees.

X _____ X _____
Parent/Guardian Signature Date

Medicare Patients: I assign payment of authorized Medicare benefits to be made on my behalf to Family Health Center for any services furnished to me. I authorize Family Health Center to release medical information of the Social Security Administration or its intermediaries or carries as required for payment. I agree to pay charges not paid within thirty (30) days after being billed.

X _____ X _____
Patient/Guardian Signature Date

PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING

CONSENT FOR BLOOD/BODY FLUID TESTING: In the event that a health care worker or emergency response person(s) is suspected to have had exposure to my blood and/or body fluids or if it is likely that a healthcare worker or emergency response person(s) is exposed to my blood and/or body fluids, due to my illness or an uncommon rare disease, I consent to have the Family Health Center determine by serological testing whether or not my blood contained contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family, as well as the health of those health care personnel or emergency response person(s) who may have been or become involved in my treatment.

CONSENT TO DISPOSAL OF TISSUE/FLUID/SPECIMANS. I agree that the Family Health Center may utilize, destroy, or dispose of any tissues, fluids, or specimens taken from me during treatment.

PROVIDER NON-DISCRIMINATION ACT: I understand that this is an equal opportunity institution. There is no discrimination because of race, color, religion, natural origin, age, sex, handicap, or inability to pay.

ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES. I hereby acknowledge that I have received a copy of the Joint Notice of Privacy Practices.

Patient/ Personal Representative Signature or Initial)

I certify that I have read and fully understand this document and that I have received a copy of it. I, as the patient/personal representative, agree to sign this document indicating that I agree with all of its terms and statements.

Patient/Personal Representative Relationship to Patient Date

Signature, Witness Date