Kearny County Hospital

www.KearnyCountyHospital.com

Kearny County Hospital	Family Health Center - Lakin	Long Term Care & Assisted Living
500 E Thorpe St.	506 E Thorpe St.	607 Court Place
Lakin, KS 67860	Lakin, KS 67860	Lakin, KS 67860
620-355-7111 (p) | 620-355-8627 (f)	620-355-7550 (p) | 620-355-8626 (f)	620-355-7836 (p) | 620-355-8645 (f)

PATIENT REGISTRATION FORM

Date: ____________________

PATIENT INFORMATION: (PROVIDE LEGAL NAME)

Name: ____________________________________ Date of Birth __________ Gender: ❑ Male ❑ Female
Last First MI

Mailing Address: ____
Street City State Zip Code

Physical Address: ____
Street City State Zip Code

SSN#: ________-__________-______________ Marital Status: ❑ Single ❑ Married – Spouse: ______________

Primary Phone#: ______________________ Home/Cell/Work

Secondary Phone#: ______________________ Home/Cell/Work

Primary Language: ❑ English ❑ Spanish

Ethnic Group: ❑ Hispanic/Latino ❑ Not Hispanic

PATIENT PORTAL EMAIL: *Security Question = Zip Code*

______________________@______________________

Authorized Representative(s)

1.____________________ 2.____________________

3.____________________ 4.____________________

5.____________________ 6.____________________

Race: ❑ White ❑ Black/African American ❑ Native
❑ Asian ❑ American Indian/Alaska ❑ Native Hawaiian/Other Pacific Islander
❑ Decline ❑ Other: ________________________________

Employment: ❑ Full Time ❑ Part Time ❑ Unemployment
❑ Student ❑ Minor/Child ❑ Retire – *Retirement Date:* ________________

Employer: ____

Employer Address: ____
Street City State Zip Code

RESPONSIBLE PARTY: (IF DIFFERENT FROM PATIENT)

Name: ____________________________________ Date of Birth __________ Gender: ❑ Male ❑ Female
Last First MI

Mailing Address:____

Street City State Zip Code

SSN#:_________-_________________-___________________

Primary Phone#:_______________________________Home/Cell/Work Secondary Phone#:_____________________Home/Cell/Work

Employment: ❑ Full Time ❑ Part Time ❑ Unemployment
❑ Student ❑ Minor/Child ❑ Retire – *Retirement Date:*______________________

Employer:____

Employer Address:____

Street City State Zip Code

Family Members for Single Billing Statement:

Name:	Date of Birth	Name:	Date of Birth
1.______________________________	_______________	2.______________________________	_______________
3.______________________________	_______________	4.______________________________	_______________
5.______________________________	_______________	6.______________________________	_______________

EMERGENCY CONTACT:

Name:____ Date of Birth: ______________________________________
Last First MI

Relationship: _______________________________________ Phone#:_________________________________Home/Cell/Work

Name:____ Date of Birth: ______________________________________
Last First MI

Relationship: _______________________________________ Phone#:_________________________________Home/Cell/Work

Name:____ Date of Birth: ______________________________________
Last First MI

Relationship: _______________________________________ Phone#:_________________________________Home/Cell/Work

I GIVE KEARNY COUNTY HOSPITAL AND ITS AFFILIATED ENTITIES (FHC/ENT) PERMISSION TO DISCUSS MY HEALTH AND/OR BILLING INFORMATION WITH

____

(LIST THE NAME OF ANY PERSON(S) WITH WHOM YOU GIVE US PERMISSION TO SPEAK WITH.)