MINDEN MEDICAL CLINIC/KEARNEY COUNTY HEALTH SERVICES		DATE:
PATIENT INFORMATION	**ADULT FORM**	
BIRTHDATE:	SSN:	MALE/FEMALE
LAST NAME:	FIRST NAME:	MIDDLE NAME:
ADDRESS:	CITY:	STATE: ZIP CODE:
COUNTY:	CELL PHONE:	HOME PHONE:
EMAIL:		PRIMARY PHYSICIAN:
ETHNICITY: *(CIRCLE ONE)*	HISPANIC OR LATINO	NON HISPANIC OR LANTINO
RACE: *(CIRCLE ONE)*	WHITE HISPANIC	ASIAN AMERICAN INDIAN
PREFERRED LANGUAGE: *(CIRCLE ONE)*	ENGLISH SPANISH	MILITARY SERVICE/VETERAN BENEFITS
MARITAL STATUS: *(CIRCLE ONE)*	SINGLE MARRIED DIVORCED	WIDOWED LIFE PARTNER

EMPLOYMENT INFORMATION				
EMPLOYER:			ADDRESS:	
CITY:	STATE:	ZIP CODE:	PHONE:	DATE OF RETIREMENT:

RESPONSIBLE PARTY ***(PERSON THAT BILL SHOULD BE ADDRESSED TO)***			
LAST NAME:	FIRST NAME:		
ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE:	E-MAIL:		
RELATIONSHIP:	EMPLOYER:	EMPLOYER PHONE:	

SPOUSE		
LAST NAME:	FIRST NAME:	BIRTHDATE:
PHONE:	EMPLOYER:	EMPLOYER PHONE:

EMERGENCY CONTACT *(OTHER THAN SPOUSE)*		
LAST NAME:	FIRST NAME:	RELATIONSHIP:
ADDRESS:		PHONE:

INSURANCE		
PRIMARY:	POLICY HOLDER:	POLICY HOLDERS DOB:
ID#:	EMPLOYER:	RELATONSHIP:
SECONDARY:	POLICY HOLDER:	POLICY HOLDERS DOB:
ID#:	EMPLOYER:	RELATIONSHIP: