MINDEN MEDICAL CLINIC/KEARNEY COUNTY HEALTH SERVICES		DATE:	
PATIENT INFORMATION	**MINOR 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	
MARITAL STATUS: *(CIRCLE ONE)*	SINGLE	MARRIED	DIVORCED WIDOWED LIFE PARTNER

MOTHER INFORMATION				
LAST NAME:	FIRST NAME:		ADDRESS:	
CITY:	STATE:	ZIP CODE:	PHONE:	BIRTHDATE:
EMPLOYER:		EMPLOYER ADDRESS:		
CITY:	STATE:	ZIP CODE:	PHONE:	

FATHER INFORMATION				
LAST NAME:	FIRST NAME:		ADDRESS:	
CITY:	STATE:	ZIP CODE:	PHONE:	BIRTHDATE:
EMPLOYER:		EMPLOYER ADDRESS:		
CITY:	STATE:	ZIP CODE:	PHONE:	

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

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