# KEARNEY COUNTY HEALTH SERVICES

DATE:

**PATIENT INFORMATION**

| | | | |
|---|---|---|---|
| BIRTHDATE: | SSN: | MALE/FEMALE | |
| LAST NAME: | FIRST NAME: | MIDDLE NAME: | |
| ADDRESS: | CITY: | STATE: | ZIP CODE: |
| COUNTY: | CELL PHONE: | HOME PH: | |
| 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

**EMPLOYMENT INFORMATION**

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|---|---|---|---|---|
| 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: | EMPLOYERS PH: | |

**SPOUSE**

| | | |
|---|---|---|
| LAST NAME: | FIRST NAME: | BIRTHDAY: |
| PHONE: | EMPLOYER: | EMPLOYER PHONE: |

**EMERGENCY CONTACT** *(OTHER THAN SPOUSE OR PARENT)*

| | | |
|---|---|---|
| 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: |