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 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

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: