NMC health

PO Box 308 | Newton, KS 67114

Date: _____

DEMO

Patient Demographics

Patient Name: _____ **Preferred Name:** _____
(First) (MI) (Last) (Suffix)

Date of Birth: _____/_____/_____ **Social Security Number:** _____ **Gender: M F**

Home Address: _____ **P.O. Box:** _____

City: _____ **State:** _____ **Zip Code:** _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Race: ☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐Hispanic ☐ Native American ☐Other:_____

Ethnicity: ☐Hispanic ☐Non-Hispanic **Preferred Language:** ☐English ☐Spanish ☐Other:_____

Preferred Phone: (_____)_____☐ Cell ☐ Home **Alternate Phone:** (_____)_____☐ Cell ☐ Home

Email: _____ **Employer:** _____ **Work Phone:** (_____)_____

Primary Care Physician/Provider (PCP): _____ **Referring Physician/Provider:** _____

How did you hear about our practice? ☐TV ☐Internet ☐Magazine ☐Newspaper ☐ Physician: _____ ☐Other: _____

Person Responsible for Payment of Account

Please complete if patient is under the age of 18 or if you would like billing information sent to someone other than the patient.

Name: _____ _____ **Social Security Number (required):** _____

Relationship: _____ Date of Birth: _____/_____/_____

Home Address: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Contact Number: (_____)_____ Employer: _____ Employer Phone: (_____)_____

Release of Information

By listing the following names, you are granting permission for us to share your information with them (**CHECK THE BOXES ON EACH PERSON FOR WHAT INFORMATION YOU WANT SHARED**)

☐ **DO NOT SHARE ANY INFORMATION WITH ANY OTHER INDIVIDUAL EXCEPT PATIENT**

Emergency Contact: _____ Relationship: _____ Phone Number: (____)_____
Information to share: ☐Emergency Contact ONLY ☐Appointments ☐Clinical ☐ Financial

1) Name: _____ Relationship: _____ Phone Number: (____)_____
Information to share: ☐Appointments ☐Clinical ☐ Financial

2) Name: _____ Relationship: _____ Phone Number: (____)_____
Information to share: ☐Appointments ☐Clinical ☐ Financial

3) Name: _____ Relationship: _____ Phone Number: (____)_____
Information to share: ☐Appointments ☐Clinical ☐ Financial

4) Name: _____ Relationship: _____ Phone Number: (____)_____
Information to share: ☐Appointments ☐Clinical ☐ Financial

_____ _____ _____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**

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