MID KANSAS WOMEN'S CENTER, PA

PATIENT REGISTRATION

☐ East Office
9300 E. 29th St. N. Ste. 201
Wichita, KS 67226
(316) 685-1277
Fax (316) 685-2135

☐ Arthur Dehart, M.D.
☐ Thalia Lopez, M.D.
☐ Johanna Agustin, M.D.
☐ Michael Bates, M.D.
☐ Rhea Rogers, M.D.
☐ Arlene Evans DeBeverly, RPA

☐ West Office
2131 N. Ridge Road
Wichita, KS 67212
(316) 721-3122
Fax (316) 721-3124

Legal Name _____SS#_____-_____-_____DOB_____-_____-_____
LAST FIRST MIDDLE

Address_____Apt_____City _____State _____Zip _____

Home Phone (_____) _____Work Phone (_____)_____Ext _____Cell Phone (_____)_____

Employer _____Employment Status FT _____PT ____Not Employed_____

Employer Address _____City _____Zip _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Spouse's Name _____DOB_____-_____-_____ SS#_____-_____-_____

Employer Address _____City _____Zip _____

EMERGENCY CONTACT

By listing the individual below as an emergency contact, you are authorizing Mid-Kansas Women's Center to release information regarding the nature of the emergency and your location.

Name_____Relationship to patient _____

Home Phone (_____) _____Work Phone (_____)_____Cell Phone (_____)_____

RESPONSIBLE PARTY INFORMATION

Complete this section if you would like Billing information to be sent to someone **OTHER THAN THE PATIENT OR INSURED.**

Name _____Relationship _____SS# _____-_____-_____DOB____-____-____

Address_____Apt_____City _____State _____Zip _____

Home Phone (_____) _____Work Phone (_____)_____Cell Phone (_____)_____

PRIVACY INFORMATION

I hereby acknowledge that I have received a copy of this Clinic's Notice of Privacy Practices.

Patient Name (print) _____Date _____

Signature of Patient / Legal Guardian:_____

Relationship _____

For Office Use Only

___ Patient received NPP and refused to acknowledge receipt at this time

Other _____

Employee Signature _____**Date**_____

PLEASE COMPLETE OTHER SIDE

Please Complete Insurance Information

Primary Care Physician _____Phone (___) _____

Address _____City _____State _____Zip _____

PRIMARY INSURANCE Insurance Company _____

Claims Address _____ City _____State _____Zip _____

ID/Policy Number _____Group Number _____Effective Date_____-_____-_____

Subscriber Name _____ Relation to Pt. _____SSN: _____DOB _____

Address _____ Apt _____City _____State _____Zip _____
(if different from patient)

Home Phone (_____) _____Work Phone (_____)_____Cell Phone (_____) _____

SECONDARY INSURANCE Insurance Company_____

Claims Address _____ City _____State _____Zip _____

ID/Policy Number _____Group Number _____Effective Date_____-_____-_____

Subscriber Name _____ Relation to Pt. _____SSN: _____DOB _____

Address _____ Apt _____City _____State _____Zip _____
(if different from patient)

Home Phone (_____) _____Work Phone (_____)_____Cell Phone (_____)_____

THIRD INSURANCE Insurance company _____

Claims Address _____ City _____State _____Zip _____

ID/Policy Number _____Group Number _____Effective Date_____-_____-_____

Subscriber Name _____ Relation to Pt. _____SSN: _____DOB _____

Address _____ Apt _____City _____State _____Zip _____
(if different from patient)

Home Phone (_____) _____Work Phone (_____)_____Cell Phone (_____)_____

I understand my signature requests that payment be made to the provider and authorizes release of medical information necessary to pay the claim. A photocopy of the authorization and assignment shall be considered as valid as the original. If item 12 of CMS-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown above in Medicare/ Other Insurance Company assigned cases. Co-pay must be paid at the time of service. Please let us know if you need more information.

A Photocopy of these assignments shall be valid as the original.

PATIENT (PRINT NAME)_____

SIGNATURE _____Today's Date _____

GUARDIAN (PLEASE PRINT) _____Today's Date _____

This is a permanent part of this medical record and shall be retained with the chart. If records are thinned this form remains a part of the primary record.