

MID KANSAS WOMEN'S CENTER, PA

PATIENT REGISTRATION

- East Office 9300 E. 29th St. N. Ste. 201 Wichita, KS 67226 (316) 685-1277 (316) 685-2135 Fax
West Office 3460 N. Ridge Rd. Ste. 130 Wichita, KS 67205 (316) 721-3122 (316) 721-3124 Fax
Medical staff: Arthur Dehart, M.D., Michael Bates, M.D., Thalia Lopez, M.D., Rhea Rogers, M.D., Johanna Agustin, M.D., Arlene Evans DeBeverly, PA-C, Aldon Corle, Jr., M.D.

Legal Name LAST FIRST MIDDLE SS# - - DOB - - -

Address Apt City State Zip

Home Phone () Work Phone () Ext Cell Phone ()

Email Address

Employer

Marital Status: Single Married Divorced Widowed Other

Spouse's Name DOB - - SS# - - -

Spouse's Employer Work Phone

- Race: Black or African American, Asian, White, Hispanic, Native Hawaiian, Pacific Islander
Ethnicity: Hispanic or Latino, Not Hispanic or Latino, Unknown, African American, Mexican American, Arab American, Native American, Jewish American, Asian American
Preferred Language: English, Spanish, Other

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 ()

For Office Use Only
Patient received NPP and refused to acknowledge receipt at this time
Other
Employee Signature Date

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 _____

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 (_____) _____

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.