Southeast Kansas Healthcare

1505 W. 4th Coffeyville, KS 67337 | (620) 251-2400 FAX (620) 251-1619

Last Name _____ First Name _____ Initial _____

Home Phone _____ Work Phone _____ Cell _____

Address _____

City _____ State _____ Zip code _____

SSN _____ Birth date _____ Gender _____

Marital Status _____ Employer _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____

How did you hear about our clinic? _____

Insurance Information:

Primary Insurance Company	ID#	Group #
Insurance owner's name	SSN	D.O.B.
Insurance owner's address	City	State Zip
Secondary Insurance Company	ID#	Group #
Insurance owner's name	SSN	D.O.B.

****

"I authorize and request payment of medical benefits to the attending practitioner for the services rendered & I authorize the practitioner to furnish any information required for the processing of my claim. I am required to pay my co-pay, deductible, & coinsurance at the time of service."

Insured's signature _____ Date _____

"As a self pay patient, I understand that I am responsible to pay for services rendered at the time of my visit."

Private Pay Signature _____ Date _____

Signature _____

All patients must sign. HIPPA: I have received notice of the privacy practice from Southeast Kansas Health Care, LLC.