Medical & Dental
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Tel: 785.238.4711
Fax: 785.238.4260

Dental Only
2030 Tecumseh Rd
Manhattan, KS
Tel: 785.320.7134
Fax: 785.320.7509

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REGISTRATION FORM

MEDICAL / DENTAL
(Please Print)

Today's date: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	Race:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security number:	Home phone number: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone number: ( )

Language(s) Spoken:	Veteran? ❑ Yes ❑ No	Agricultural Worker? ❑ Yes ❑ No	Homeless? ❑ Yes ❑ No

Parent/Guardian Name:	Phone: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Subscriber Information:	Birth date: / /	Address (if different):	Home phone number: ( )

Is this person a patient here? ❑ Yes ❑ No SSN#

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone number: ( )	Work phone number: ( )

Authorized to release information ❑ Yes ❑ No Do you have Advanced Directive or Living Will ❑ Yes ❑ No

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Konza Prairie Community Health Center or insurance company to release any information required to process my claims.

Patient/Guardian Signature ***Date***