SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

Date:_____

ADULT PATIENT DEMOGRAPHIC FORM
PLEASE PRINT CLEARLY

PATIENT INFORMATION

Patient's Full Legal Name

Last:	First:	Middle Initial:

Preferred Name:	Social Security Number:	Date of Birth:	Sex:
	- -	/ /	☐ Male ☐ Female

Race: ☐ African American/Black ☐ Asian ☐ Native American ☐ Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address / PO Box:	Lot / Apt #:	City:	State:	Zip Code:

Primary Phone #:	Cell/Mobile?	Leave Message?	Secondary Phone #:	Cell/Mobile?	Leave Message?
( )	☐ Yes ☐ No	☐ Yes ☐ No	( )	☐ Yes ☐ No	☐ Yes ☐ No

Email Address:	Preferred Language:

Patient Guardian Full Name (If Applicable)	Relationship:	Phone #:	City & State:
		( )	

PATIENT'S CURRENT HEALTHCARE PROVIDER INFORMATION

Primary Care Physician/Provider:	Referring Physician/Provider:

Preferred Hospital:	Preferred Pharmacy:

PATIENT'S CURRENT EMPLOYMENT/STUDENT STATUS

Employer:	Employment Status:	Student Status:
	☐ FT ☐ PT ☐ Self ☐ Military ☐ Unemployed ☐ Retired ☐ Disabled	☐ FT ☐ PT ☐ Not a Student

Employer Address:	Employer Phone:	Name of School:
	( )	

BILLING/INSURANCE INFORMATION

Primary Health Insurance Company:	Policy Holder Full Name:	Policy Holder Date of Birth:

Secondary Health Insurance Company:	Policy Holder Full Name:	Policy Holder Date of Birth:

EMERGENCY CONTACT INFORMATION & DISCLOSURE

Primary Emergency Contact Full Name:	Relationship:	Phone #:	City & State:
		( )	

Secondary Emergency Contact Full Name:	Relationship:	Phone #:	City & State:
		( )	

I understand that it is my right to elect to whom my medical, insurance and/or financial information can be released. For our records the person/s listed above will be your emergency contact/s. I also understand that if I choose to leave this information blank, the facility will not have an emergency contact or be able to release any information to anyone, including my spouse/significant other, children, parents, siblings, etc. I therefore authorize KUSM-W Medical Practice Association to release my information as directed below.

AUTHORIZATION & ACKNOWLEDGEMENT

I do hereby authorize the release of any medical information necessary to process claims on my behalf. I request that all insurance benefits be paid directly to KUSM-W Medical Practice Association for all charges incurred by me. I understand that I am responsible for all charges incurred during my treatment at KUSM-W Medical Practice Association Clinics regardless of insurance coverage. I agree to pay the entire balance of my account in a timely manner. I also authorize KUSM-W Medical Practice Association to release and obtain necessary information to/from the emergency contact/s, listed above, in the event of an emergency or loss of communication between KUSM Medical Practice Association and Patient. I acknowledge that I have received a copy of the KUSM-W Medical Practice Association Notice of Privacy Practices.

_____ _____
Signature of Patient, Responsible Party, or Authorized Legal Representative **Date**

_____ _____
Printed Name of Patient, Responsible Party, or Authorized Legal Representative **Relationship to Patient**

_____ _____
Witness Signature **Date**