Heart of Kansas Family Health Care, Inc.
"We Care about your Health"

Patient Demographic Information

Please Print

IF PATIENT UNDER AGE 18 MUST BE ACCOMPANIED BY PARENT OR LEGAL GUARDIAN

Is patient in Foster Care, Juvenile Intake, DCF, SRS or state custody? YES or NO

Patient's Full Legal Name _____

Preferred Name (if different) _____

Date of Birth___/___/_____ **Social Security #**_____ **Sex** at birth M F

Please check ALL that apply in each category

These questions and answers help us with our grant reporting and funding

Sexual Orientation	
	Lesbian or Gay
	Straight (not lesbian or gay)
	Bisexual
	Don't know
	Something else
	Choose not to disclose

Gender Identity	
	Male
	Female
	Transgender Male (Female-to-Male)
	Transgender Female (Male-to-Female)
	Other
	Choose not to disclose

Street Address _____ PO Box_____

City_____ **State** _____**Zip**_____

Phone: (H)_____ (C)_____(W)_____

Email address_____ **(for Patient Portal)**

Email me for Reminders YES NO **Text appt reminders YES NO**

Pediatric Details if patient is under age 18:

Mother's Name: _____ **Father's Name:**_____

Person responsible for the bill (if different from the patient):_____

Why is this person responsible? _____

Guarantor:

Name: _____ **SS#** _____

Date of Birth _____ **Gender:** M F

Address _____**City:**_____ **State** _____**Zip** _____

Home Phone _____ **Cell Phone** _____

Employer Name: _____ **Employer Phone:** _____

Insurance Company Name: _____

Policy Holder Name _____ **Policy Holder DOB** _____

Policy _____ **Group #** _____

Please have your insurance card available for us to copy

5-2018

Heart of Kansas Family Health Care, Inc.
"We Care about your Health"

Patient Demographic Information

Please Print

Please check ALL that apply in each category

THESE QUESTIONS AND ANSWERS HELP US WITH OUR GRANT REPORTING AND FUNDING

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced / separated
- ☐ Remarried
- ☐ Living together
- ☐ Widowed

Student
- ☐ Full-Time
- ☐ Part-Time
- ☐ Not in School

Employment
- ☐ Disabled
- ☐ Full time
- ☐ Part time
- ☐ None
- ☐ Retired
- ☐ Self Employed

Race:
- ☐ African American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ White
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Prefer not to reply

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino

Language
- ☐ English
- ☐ Spanish
- ☐ Other:_____
- ☐ Interpreter Needed

Housing
- ☐ Not Homeless
- ☐ Doubling up/staying w friends
- ☐ Public Housing
- ☐ Street
- ☐ Shelter
- ☐ Transitional

Military Service
- ☐ I HAVE served in military
- ☐ I have NOT served military

Agricultural Status
- ☐ Dependent of Migrant
- ☐ Dependent of Seasonal worker
- ☐ Migrant Worker
- ☐ Seasonal Worker
- ☐ Not Agricultural Worker

Local Pharmacy: _____

Mail Pharmacy: _____

Circle the yearly income range before taxes below the number of people in the household

	1 Person	2 People	3 People	4 People	5 People	6 People	7 People	8 People
Under	$12,060	$16,240	$20,420	$24,600	$28,780	$32,960	$37,140	$41,320
Between	$12,061-$21,104	$16,240 to $24,360	$20,421 to $30,630	$24,601 to $36,900	$28,781 to, $43,170	$32,961 to $49,440	$37,140 to $55,710	$41,321 to $61,980
Between	$21,105 to $24,119	$24,361 to $32.480	$30,631 to $40,840	$36,901 to $49,200	$43,171 to $57,560	$49,441 to $65.920	$55,711 to $74,280	$61, 981 to $82,640
Over	$24,120	$32,480	$40,840	$49,200	$57,560	$65,920	$74,280	$82,640

*If you wish to apply for reduced fees, you are required to present all sources of income including wages, unemployment, social security, worker's comp, SSI, SRS, child support, veteran's benefits, alimony, food stamps, savings and any resources available to the patient/family.

Certification: I certify that the information given in this form is true and accurate. This may be verified.

_____ _____

Signature of Patient **Date** **Signature of Parent if minor** **Date**

5-2018