Welcome

Reno County Health Department

Patient # (For Office Use Only)

Legal Name Of Person Receiving Service: (Please Print)

Last _____ First _____ MI ___

Birth date ___/___/___ Social Security # _____

Address _____ County _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

May we send mail to the above address? Yes No Physician _____

May we contact you at the above phone number? Yes No

If no, how can we contact you? _____

Employer _____ Work Phone # _____

Previous names used at the Health Department _____

List any known allergies to medications _____

Emergency Contact _____ Phone # _____

Are you, or others living in your home, migrant workers? Yes No

For Statistical Purposes Only (Please Circle All That Apply)

Sex: Male Female **Marital Status:** Single Married Divorced Widowed

Race: Asian Black/African American Am. Indian/Alaska Native Native Hawaiian/Pacific Islander White Unknown/Not Reported

Ethnicity: Hispanic/Latino Non-Hispanic **If Hispanic, Please Choose Origin:** Mexican Cuban Puerto Rican Central/South American Other/Unknown

Language _____ **Highest Grade Completed:** ___

Na

Last _____ First _____ MI ___

Address _____ Phone # _____

City _____ State _____ Zip _____

Birth date ___/___/___ Social Security # _____

Name And Address Of Responsible Party: (Person responsible for paying bill)

Last _____ First _____ MI ___

Address _____ Phone # _____

City _____ State _____ Zip _____

Birth date ___/___/___ Social Security # _____

How many people are in your household? _____

Income Documentation

The Health Department has a reduced (sliding scale) fee schedule based on income and number in household which could reduce cost of services. Please fill out the Income Documentation Section below.

List all members in household	Gross	Per

Other Income

Cash Assistance		
Unemployment		
Social Security		
SSI Benefits		
Child Support/Alimony		
Other (list)		
Proof of Income Used		
Self Declaration Used		

REFUSED ☐

Verified By _____ Date _____

If you provide us a copy of your Health Insurance, Medicare and/or Medicaid card we will submit your claim for service to your insurance provider. If an insurance claim is denied, services will be billed to you for full charge unless the Income Documentation section has been completed and qualifies you for a reduced rate.

Primary Insurance Coverage: Please Circle all that apply

Medicare Medicaid Sunflower United HealthCare AmeriGroup Other Public Insurance Private Insurance No Coverage Unknown

Insurance	Policy Number / Social Security Number	Name Of Policy Holder	Policy Holder's Birth date

Please read before signing.

The above information, to the best of my knowledge and belief, is true, correct and complete.

I authorize Reno County Health Department to use protected health information concerning the above named person.

I authorize the release of only the medical or billing information necessary to process claims for insurance providers including Medicare or Medicaid.

I request payment of insurance benefits to the Reno County Health Department.

I consent to the inclusion of immunization data in the Kansas Immunization Registry for myself and the person named above.

Signature of person completing this form _____ Date _____