KU 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:** / /		**Gender:** ☐ M ☐ F ☐ T ☐ NB	
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?** ☐ Yes ☐ No	**Leave Message?** ☐ Yes ☐ No	**Secondary Phone #:** ( )	**Cell/Mobile?** ☐ Yes ☐ No	**Leave Message?** ☐ 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:** ☐ FT ☐ PT ☐ Self ☐ Military ☐ Unemployed ☐ Retired ☐ Disabled	**Student Status:** ☐ 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**