Partners in Family Care

200 E Pack St
Moundridge, KS
620.345.6322

101 W Gordon
Inman, KS
620.585.6416

371 N Old Hwy 81
Hesston, KS
620.327.2314

1800 E Gordon St
McPherson, KS
620.242.0404

Patient Information Today's Date_____

First Name_____ MI _____ Last Name _____ Birth Date_____

Prefers to go by:_____ Male ❒ Female ❒ Race: ☐ White/ ☐ African Am/ ☐ Asian/ ☐ Am Indian/ ☐ Other

Marital Status S / M / W / D Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other

Mailing Address: PO Box_____ Apt #; _____ Your Social Security # _____ _____ _____

Street Address:_____ City:_____ St:_____ Zip_____

Home Phone (_____)_____ Cell (_____)_____ Work (_____)_____ First choice of contact Hm# Ce# Wk#

Employer_____ Employer Address & Phone: _____

Spouse's Name:_____ Birth Date: _____ Spouse's SS#_____

In Case of Emergency, Contact_____ Relationship to patient_____ Phone #_____

Address of Emergency Contact_____

How did you choose Partners In Family Care? _____

Who do you want as your Primary Care Provider (PCP)? _____

Person Financially Responsible

First Name: _____ MI_____ Last Name: _____ M / F Birth Date:_____

Marital Status S / M / W / D SS#_____ Mailing Address: PO Box_____ Apt #_____

Street Address: _____ City: _____ St: _____ Zip_____

Home Phone (____)_____ Cell (____)_____ Work (____)_____

Relationship to Patient_____ Employer_____

Medical Insurance

Primary Insurance_____

Address_____

ID/Policy#_____ **Group#** _____

Name of Insured_____

Birth Date_____ **Employer**_____

Relationship to Patient_____

Secondary Insurance_____

Address_____

ID/Policy #_____**Group#**_____

Name of Insured_____

Birth Date_____ **Employer**_____

Relationship to Patient_____

If there is additional information insurance or other, please provide information on the back of this form.