Thank you for choosing Community Health Center of Southeast Kansas, Inc. (CHC/SEK) for your child's health care needs. CHC/SEK's school health clinic(s) is available for all students. If you have any questions call 620.240.5061. *Please complete this form in ink.*

PATIENT INFORMATION

Full Legal Name

Last Name:	First:	Middle:

Date of Birth_____ Male❑ Female ❑ Social Security Number_____

Mailing Address_____ City _____

State & Zip _____ E-Mail Address_____ Phone Number_____

Do you want to access your medical records electronically? Yes No
(If yes, you will receive an email, at the email address listed above, from CHC/SEK with your log-in information and the log-in URL.)

Preferred method of communication for appointment reminders: ❑ Text ❑ Phone Call

Race:
❑American Indian/Alaskan
❑Asian
❑Native Hawaiian
❑Black or African American
❑White/Hispanic
❑Pacific Islander
❑Other Race

Ethnicity:
❑Hispanic/Latino
❑Not Hispanic/Latino

Preferred Language
❑English
❑Spanish
❑Other _____

If you are Homeless, are you:
❑On the Street
❑Doubling Up
❑In Transitional Housing
❑In a Shelter
❑Other

Other than CHC/SEK's school health clinic(s), who does the patient use for his/her medical care?
(Check all that apply) ❑CHC/SEK ❑Other:_____ ❑N/A

RESPONSIBLE CAREGIVER

Name_____
Date of Birth _____
Relationship to the Patient_____
Mailing Address _____
City, State, Zip _____
Phone Number _____

Name_____
Date of Birth _____
Relationship to the Patient_____
Mailing Address _____
City, State, Zip _____
Phone Number _____

(If Responsible Caregiver(s) is a foster parent or out-of-home placement, please provide appropriate paperwork illustrating placement and appropriate paperwork illustrating who maintains authority to make medical decisions on the patient's behalf).

EMERGENCY CONTACT

In the event of an emergency, who should we contact? _____

Relationship to Patient: _____

Home Number_____ Cell Number_____ Work Number_____

Please Complete the Back of Form

INSURANCE INFORMATION (Check all that apply)

❑KanCare (Aetna, Sunflower, United HealthCare)
❑Other Medicaid
❑No Health Insurance (Staff are available to help determine if you are eligible for coverage)
❑Commercial Insurance
❑Medicare

Primary Insurance	**Secondary Insurance**
Insurance Plan_____	Insurance Plan_____
Member ID Number _____	Member ID Number _____
Group Number _____	Group Number _____
Policy Holder Information:	**Policy Holder Information:**
Full Name _____	Full Name _____
Date of Birth _____	Date of Birth _____
Social Security Number _____	Social Security Number _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____

Pharmacy: _____ _____
Name City & State

* Apothecare, physically located inside CHC/SEK's Pittsburg Clinic, is CHCSEK Pittsburg's preferred pharmacy.
* The Prescription Shop, physically located at 601 W. 11th St., is CHCSEK Coffeyville's preferred pharmacy.