Knox County Community Health Clinic

PATIENT INFORMATION

Patient Name____
Last **First** **Middle**

Patient Birth Date______________________ **Age**__________ ❐ **Female** ❐ **Male**

Social Security Number____________________ □ **Single** □**Married** □**Divorced** □**Separated** □**Widowed**

Address____
Street **City** **State** **Zip**

School______________________ **Grade**____________

Telephone Home(______)____________Work(_____)____________Mobile(______)____________

Employer Name____

Emergency Contact____________________ **Relationship** ____________ **Telephone**____________

PARENT/GUARDIAN INFORMATION

Name ____
Last **First** **Middle**

Address ____
Street **City** **State** **Zip**

DOCTOR OR OTHER HEALTH CARE PROVIDER

Name of Doctor or Other Provider ______________________________

Telephone Number of Doctor or Other Provider (________)______________________________

Address of Doctor or Other Provider ______________________________
Street **City** **State** **Zip**

Hospital Preference____

RACE

❐ **American Indian** ❐ **Asian** ❐ **Hawaiian/Pacific Islander**
❐ **Black/Hispanic** ❐ **Black/Non-Hispanic** ❐ **White/Non Hispanic** ❐ **White/Hispanic**
❐ **Mixed Race** ❐ **Unknown**

PREFERRED LANGUAGE

❐ **English** ❐ **Spanish** ❐ **Other (specify)** ____________________

Please turn over and complete top half of other side

❒ **YES, WE HAVE INSURANCE**

IF YOU HAVE HEALTH INSURANCE PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (FRONT & BACK)

❒ MEDICAID/ALL KIDS/KIDCARE ❒ HMO ❒ PPO/POS ❒ Indemnity/Fee for Service

Name of insurance company ___________________________________

❒ **NO, WE DO NOT HAVE INSURANCE**

____ _____________________

Signature **Date**

FOR OFFICE USE ONLY

Number of people responsible for ______________________________

Poverty Level	
0-100%	
101% - 150%	
151% - 200%	
201% - 250%	
250% and up	

Medicare # ____

Illinois Public Aid # ____

Spin down YES NO

Insurance # ____

Primary Insurance ____

Secondary Insurance ____

Co pay $ ___________________________ Fee for Service $ ___________________________

Information Verified							
Date	**Initials**	**Date**	**Initials**	**Date**	**Initials**	**Date**	**Initials**

Comments