Heart of Kansas Family Health Care, Inc.
"We Care about your Health"

Patient Demographics/Fill Out Completely

Patient Legal Name:

First Name _____**Middle Name** _____**Last Name**_____

Preferred Name (Only if different) _____ **Sex at Birth: M F**

Date of Birth: _____/_____/_____ **Social Security#**_____

Phone: (H)_____**(Cell)**_____**(W)**_____

Best Number to call you: ☐ **Home** ☐ **Cell** ☐ **Work** **Best time to call you:** _____

PO Box: _____**Physical Billing Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

Patients under the age of 18 years: **(Please enter Full Names)**

Mother: _____Phone# _____ **Father:** _____ Phone# _____

Legal Guardian Name (documents): _____**Relationship:** _____ Phone#: _____

Let us help you create your patient portal account! **Email required** _____

Patient Portal: Helps you manage your health anytime, anywhere. Scheduled appointments, send messages, or sent refill requests to us, view your test results and billing information. Pay your bill online, without having to wait on the phone.

Would you like to receive the following: Appointment reminders, Health Notifications, Lab results, Billing Information. **(Choose any or all options)**

EMAIL YES / NO **TEXT** YES / NO **CONSENT TO CALLS** YES /NO

In case of an Emergency who should we contact: ☐ **No Emergency Contact**

Full Name: _____Relationship: _____Phone#: _____

Please Check ALL that Apply in each category

The following questions helps us with our grant reporting & funding to meet our patient's needs.

Language

	English
	Spanish
	Other:

Marital Status

	Single
	Married
	Divorced/Seperated
	Partner
	Widowed

Race

	African American/Black
	American Indian Native Alaska
	Asian
	White
	Native Hawaiian
	Other Pacific Island
	Choose not to answer

Ethnicity

	Hispanic/Latino
	Non-Hispanic/Latino

Sexual Orientation

	Lesbian or Gay
	Straight or Heterosexual
	Bi-sexual
	Something else Describe:
	Don't Know
	Choose not to answer

Gender Identity

	Male
	Female
	Transgender Male (F to M)
	Transgender Female (M to F)
	Other Describe:
	Unknown
	Choose not to answer

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Agriculture Status

	No
	Yes : Migrant or Seasonal

Homeless Status

	No
	Yes

Do you receive health care at a school-based Center ?

	No
	Yes

Public Housing

	No
	Yes

Veteran Status

	No
	Yes

Is Minor in DCF, State Custody or other?

	No
	Yes

Current Employment

	Choose not to answer
	Full time/Self employed
	Other Wise Unemployed: Retired/Disable/Student
	Part time/Temporary work
	Unemployed

Are you worried about losing your home?

	No
	Yes
	Choose not to answer

Has lack of transportation kept you from Appointments?

	No
	Yes
	Choose not to answer

Has lack of transportation kept you from Work?

	No
	Yes
	Choose not to answer

How often do you talk to people that you care about and feel close to?

	1 to 2 times a week
	3 to 5 times a week
	5 or more times a week
	Choose not to answer
	Less than a week

Stress is when someone feels tense, nervous, anxious, or can't sleep because their mind is troubled. How stressed are you?

	A little bit
	Choose not to answer
	Not at all
	Quite a bit
	Some what
	Very much

In the past year, have you or any family member you live with been unable to get any of the following when it was really needed?

	Food
	Clothing
	Medicine
	Childcare
	Phone
	Utility
	Choose not to answer

Interpreter Needed?

	No
	Yes

What is the highest level of school you have finished?

	Choose not to answer
	High school diploma or GED
	Less than High school
	More than High school

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Guarantor (Financially Responsible): ☐ **SELF – (Patient)**

Patients over the age of 18 are responsible for their own account. (Some Exceptions may apply)

What is the guarantor Relationship to the Patient? _____
Name: _____ SS#_____ Sex: M F
Date of Birth: _____ Phone#_____
Physical Address: _____City: _____State: _____Zip Code: _____
Employer Name: _____Employer Phone#: _____

Do you have Insurance? YES / NO **Medicare: YES / NO** **Kan Care/Medicaid: YES / NO**

Name of Insurance: _____
Primary -Insurance Policy Holder Name: _____ Policy Holder DOB: _____
Policy Holder Social Security: _____Phone/Cell: _____
Policy #: _____Group #: _____ Relationship to patient: _____

Name of Insurance: _____
Secondary- Insurance Policy Holder Name: _____ Policy Holder DOB: _____
Policy Holder Social Security: _____ Phone/Cell: _____
Policy #: _____ Group #: _____ Relationship to patient: _____

Sliding Fee Discount:
Did you know? Anyone can apply for our sliding fee discount. Even if you have health insurance your household may apply. To see if your household qualifies for a discount ask for a sliding fee application.

(Please refer to the chart below)

Please circle the yearly income range before taxes below the number of people in the household:

	1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 Persons
Under	$15,060	$20,440	$25,820	$31,200	$36,580	$41,960	$47,340	$52,720
Between	$15,061 to $ 22,590	$20,441 to $30,660	$25,821 to $38,730	$31,201 to $46,800	$36,581 to $54,870	$41,961 to $62,940	$47,341 to $71,010	$52,721 to $79,080
Between	$22,591 to $30,120	$30,661 to $40,880	$38,731 to $51,640	$46,801 to $62,400	$54,871 to $73,160	$62,941 to $83,920	$71,011 to $94,680	$79,081 to $105,440
Over	$30,121	$40,881	$51,641	$62,401	$73,161	$83,921	$94,681	$105,441

Pharmacy: _____ **Dental Provider: _____**

I prefer follow up appts on these days: _____ ☐ **Morning** ☐ **Afternoon**

Certification: I certify that the information given in these forms is true and accurate. I have answered the information to the best of my knowledge and ability. I have been given the opportunity to review, fully understand and accept, all terms and policies. This may be verified.

_____ _____
Patient Signature **Date** **Signature of Parent if Minor** **Date**

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