HARDER family practice P.A.

2820 Ohio / Augusta, Kansas 67010 / 316-775-7500

PATIENT INFORMATION

Legal Name: _____ _____ _____ Date Of Birth: _____/_____/_____
Last First MI

Birth Sex: M___ F____ Social Security #: _____ -_____-_____ Marital Status: S ____ M ____ D ____ W ____ Other ____

Address _____Apt _____ City _____ State _____ Zip Code _____

Preferred Phone Number: (____)_____

Preferred Contact Method (check one): Phone _____ Mail _____ Email _____ Text _____

Preferred Reminder Method (check one): Phone _____ Mail _____ Email _____ Text _____

Email Address _____

INSURANCE INFORMATION

Name of Policy Holder: _____ Policy Holder Date Of Birth: _____

Policy Holder Social Security Number: _____ Policy Holder Phone Number: _____

RESPONSIBLE PARTY INFORMATION

Complete this section if you would like billing information to be sent to someone **OTHER THAN THE PATIENT.**

Name _____ Relationship _____ SS#_____-_____-_____ DOB ____-____-_____

Address _____Apt _____ City _____ State _____ Zip _____

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

Email: _____

CONSENT TO CONTACT

I give Harder Family Practice, PA permission to speak to the following person/person's regarding any pertinent medical information.

Name: _____ Relationship to patient: _____

Phone Number: (____) _____

_____ _____
Signature of Patient or Parent/Guardian **Date**