

**KERN VALLEY HEALTHCARE DISTRICT
PATIENT INFORMATION FORM**

TODAYS DATE _____

FIRST

MIDDLE

LAST

PATIENT'S NAME _____ DATE OF BIRTH _____

AGE _____ SOCIAL SECURITY# _____ Gender: Male Female Other

MAILING ADDRESS _____ PO BOX _____

CITY, STATE, ZIP _____

HOME PH _____ CELL _____ EMAIL _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SMOKER: Y N FORMER

SPOUSE'S NAME _____ DATE OF BIRTH _____ PHONE _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____ PHONE _____

Medicare Patients:

Is visit due to an accident? Yes No If yes please circle one: Auto / WC / Other 3rd party Liability

EMPLOYMENT STATUS: FT PT SELF EMP UNEMPLOYED RETIRED DISABLED

EMPLOYER _____ PHONE _____

ADDRESS _____ CITY, STATE, ZIP _____

PRIMARY LANGUAGE: ENGLISH SPANISH OTHER _____

RACE (CIRCLE UP TO FIVE): WHITE ASIAN NATIVE HAWAIIAN (OR) PACIFIC ISLANDER OTHER RACE

BLACK (OR) AFRICAN AMERICAN AMERICAN INDIAN (OR) ALASKAN NATIVE UNKNOWN/REFUSED TO REPORT

EHTINICITY (CIRCLE ONE): HISPANIC/ LATINO NOT HISPANIC/LATINO UNKNOWN/REFUSED TO REPORT

PRIMARY INS _____ POLICY# _____ GROUP# _____

SECONDARY INS _____ POLICY# _____ GROUP# _____

PRIMARY CARE PHYSICIAN _____