



KANSAS CITY INTERNAL MEDICINE PATIENT REGISTRATION

OFFICE USE ONLY

Today's Date _____ Account # _____ Primary Doctor _____ Primary Office _____

PATIENT INFORMATION

NAME: _____ (first) _____ (middle initial) _____ (last) Email: _____
please initial to approve using for reminder calls & other general medical news _____

ADDRESS: _____ (number and street) _____ (apt #) _____ (city) _____ (state) _____ (zip code)

PRIMARY PHONE #: _____ SECONDARY PHONE #: _____ OK TO LEAVE MESSAGE: Yes No

BIRTH DATE: _____ GENDER: Female Male MARITAL STATUS: _____

RACE: _____ PRIMARY LANGUAGE: _____ SS #: _____

EMPLOYER / SCHOOL: _____ EMPLOYER PHONE: _____

ADDRESS: _____ (number and street) _____ (apt #) _____ (city) _____ (state) _____ (zip code)

OCCUPATION: _____ BY WHOM WERE YOU REFERRED: _____

OTHER PHYSICIANS INVOLVED IN YOUR CARE: _____

IN CASE OF AN EMERGENCY

NAME: _____ RELATIONSHIP: _____

PHONE#: _____ ALTERNATE PHONE#: _____

HEALTH INSURANCE INFORMATION

*please be aware that KCIM is not responsible for verification of in-network participation with your insurance carrier _____ initial

PRIMARY INSURANCE

SECONDARY INSURANCE

INSURANCE NAME _____

INSURANCE NAME _____

ID# _____ GROUP# _____

ID# _____ GROUP# _____

POLICY OWNER NAME _____

POLICY OWNER NAME _____

POLICY OWNER DOB & RELATIONSHIP TO PATIENT _____

POLICY OWNER DOB & RELATIONSHIP TO PATIENT _____

I hereby authorize Kansas City Internal Medicine to release medical information necessary for insurance reimbursement. I hereby authorize and assign payment directly to KCIM for insurance benefits herein specified and otherwise payable to me. I understand that I am financially responsible to KCIM for all charges incurred regardless of potential insurance benefits.

X _____
Signed

X _____
Date