O'SHEA MEMORIAL CLINIC

809West Bramley Street, P.O. Box 310
Jetmore, KS 67854
Phone: 620-357-8354
Fax: 620-357-6103

O'SHEA MEMORIAL CLINIC PATIENT INFORMATION

OFFICE VISIT CO-PAYS ARE DUE UPON ARRIVAL / AT TIME OF SERVICES. THANK YOU!

Today's Date: _____ Age: _____ Sex: _____

Patient Name: _____SS#: _____

Address: _____ Zip: _____County: _____

Home #: _____ Cell #: _____

Email: _____

DOB: _____ Marital: M D S W Primary Language: _____

Employer/Student: _____ Race: _____ Ethnicity: _____

Employer Address: _____ Phone #: _____ City: _____

School Name/Address: _____ City: _____

Do you have an Advance Directive (Examples: DNR, POA, Living Will, etc)? Y N Unknown

INSURANCE INFORMATION

Please hand your card to the receptionist to be scanned

Insured Name (Policy Holder): _____ Relationship: _____

D. O. B. _____ SS#: _____

Primary Insurance: _____ Policy #: _____

Group #: _____ I.D. #: _____

Is this insurance through an employer? Y N Employer Name: _____

Address: _____ Phone #: _____

Secondary Insurance: _____ Insured Name: _____

Policy #: _____ Group #: _____ I.D. #: _____

PRIMARY REPSONSIBLE BILLING (GUARANTOR) PARTY

Name: _____ Relationship: _____

Phone #: _____ DOB: _____ SS #: _____

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Address: _____ City: _____ State: _____

Employer: _____ Address: _____

Employer Phone # :_____ City: _____ State: _____

SECONDARY REPSONSIBLE BILLING (GUARANTOR) PARTY

Name: _____ Relationship: _____

Phone #: _____ DOB: _____ SS #: _____

Address: _____ City: _____ State: _____

Employer: _____ Address: _____

Employer Phone # :_____ City: _____ State: _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Address: _____ Phone #: _____

Consent for Treatment and Release of Information: I acknowledge that I do consent to have this information used as a basis for my care and treatment, arrange for billing and payment for my care and to arrange to carry out routine healthcare. I hereby authorize my attending physician or designee to administer such treatment and medications as are necessary in that provider's opinion. This includes medical testing.

I authorize the release of any medical information necessary to my insurance company. I agree to assign benefits to clinic. If insurance does not pay for this bill, I understand and agree that I am responsible for payment. If I do not have insurance, I understand I am responsible for this bill. I certify statements above in reference to credit are true and correct and I authorize investigation if necessary.

Responsible Party Signature: _____

Witness: _____ Date: _____

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I give O'Shea Memorial Clinic permission to discuss and or release my information to the following person(s) this choice may be changed at any time in writing:

Name: _____ Relationship: _____

Phone #: _____

Address: _____ City: _____ State: _____

Name: _____ Relationship: _____

Phone #: _____

Address: _____ City: _____ State: _____

Patient/Responsible Party Signature: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____