

Account  
 New # \_\_\_\_\_  
 Old # \_\_\_\_\_  
 Update \_\_\_\_\_  
Reason \_\_\_\_\_

**KEARNEY CLINIC, P.C.**  
PATIENT INFORMATION  
(PRINT CLEAR AND COMPLETE)

Dr. being seen \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name (L) \_\_\_\_\_ (F) \_\_\_\_\_ (MI) \_\_\_\_\_ Sex \_\_\_\_\_  
Street Address \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
Mailing Address \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver's License # and State \_\_\_\_\_  
Maiden Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Family Doctor \_\_\_\_\_ Occupation ( ) \_\_\_\_\_ Employer ( ) \_\_\_\_\_  
Spouse \_\_\_\_\_ Spouse Employer \_\_\_\_\_  
Other family members \_\_\_\_\_

**COLLEGE STUDENT**

Student \_\_\_\_\_ Yes \_\_\_\_\_ No Athlete \_\_\_\_\_ Yes \_\_\_\_\_ No Sport \_\_\_\_\_  
College Name \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Student Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**RESPONSIBLE PARTY**

Person Responsible for Payment (L) \_\_\_\_\_ (F) \_\_\_\_\_ (MI) \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Relationship To Patient \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Street Address \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Responsible Party S.S.N. \_\_\_\_\_  
Occupation ( ) \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Coverage: \_\_\_\_\_ Yes \_\_\_\_\_ No Medicaid: \_\_\_\_\_ Yes \_\_\_\_\_ No Medicare: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Primary Medical Insurance \_\_\_\_\_ Effective Date \_\_\_\_\_ Co-pay \_\_\_\_\_  
SS/ID # \_\_\_\_\_ Group/Policy # \_\_\_\_\_ Employer name \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Birth date \_\_\_\_\_  
Insurance Address Street \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ Effective Date \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_  
SS/ID # \_\_\_\_\_ Group/Policy # \_\_\_\_\_ Employer Name \_\_\_\_\_  
Insurance Address Street \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**Was this an accident or injury** \_\_\_\_\_ No \_\_\_\_\_ Yes Accident Date \_\_\_\_\_ Type: Worker's Comp/motor vehicle  
Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

**Emergency Contact Other than above** Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Street Address \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

**Patient Responsibility** – I, the undersigned, agree to permit Kearney Clinic to provide medical services to me. I realize that insurance reimburses me for fees paid to the doctor, and is not a substitute for payment. Late charges will be assessed at 16% per annum, commencing 60 days from first statement. I agree that I am responsible for payment of said services.

**CLINIC POLICY IS PAYMENT FOR SERVICES ON DAY OF SERVICE.**

I authorize disclosure of portions of the patient record to determine liability for payment and/or obtain reimbursement. **I, thereby assign all medical/surgical benefits to which I am entitled to the Kearney Clinic, P.C. I understand that I am financially responsible for all charges whether or not paid by insurance.**

Date \_\_\_\_\_ Signature \_\_\_\_\_ Witness \_\_\_\_\_

Chart # \_\_\_\_\_