PLEASE FILL IN ALL FIELDS

CENTRAL KANSAS ORTHOPEDIC GROUP

PATIENT INFORMATION

Last Name______________________________**First**____________________**Middle**__________

Social Security #________-________-__________ **Sex M** ☐ **F** ☐ **DOB**____________________

Status ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

Ethnicity ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Unknown** ☐ **Decline to Specify**

Race ____________________ **Preferred Language** ☐ **English** ☐ **Spanish** ☐ **Other** ________________

Address______________________________**City/State/Zip**______________________________

County __________________ **Employer**____

Email: ______________________________________

Phone(H) ______________________**(C)** ______________________**(W)** ______________________

Primary Care Doctor ______________________________**Referring Doctor**________________________

Pharmacy Preference/City____

Emergency Contact ______________________________**Phone**____________**Relationship** __________

Primary Insurance ______________________**Subscriber Name**______________________ **DOB**________

Secondary Insurance ____________________**Subscriber Name**______________________ **DOB**________

Insured/Responsible Party ____**Relationship** ____________

Social Security #________-________-__________ **Sex M** ☐ **F** ☐ **DOB**____________________

Address______________________________**City/State/Zip**______________________________

Phone(H)____ ____________________**(C)** ______________________**(W)**______________________

Is this visit due to an accident/injury ☐ **No** ☐ **Yes (If yes, date of injury** ________ **Must complete CKOG Accident Form)**

Is this a Workman's Comp Claim ☐ **No** ☐ **Yes**

____ ______________________________

Patient/Responsible Party Signature **Date**