DOCTORS WITHOUT DELAY
Rooks County Health Center
1210 N Washington | P.O. Box 389
Plainville, KS 67663
DocsWithoutDelay.com
785.688.DOCS(3627)

PATIENT INFORMATION FORM

PATIENT INFORMATION

CONTACT INFORMATION

Last Name: _____

First Name: _____ Middle Initial: ____

Birth Date: _____ /_____ /_____ Sex: M / F

Social Security Number: _____ - _____ - _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

RELATED INFORMATION

Employer: _____

Work Phone: (_____)_____

Is Patient Retired? Y / N

Date Of Retirement: _____ /_____ /_____

Regular Physician: _____

Does Patient Have The Following On File At RCHC?
(If unsure, please mark "No".)

Living Will: Y / N

Durable Power Of Attorney: Y / N

SPOUSE INFO *(If applicable)*

CONTACT INFORMATION

Last Name: _____

First Name: _____ Middle Initial: ____

Birth Date: _____ /_____ /_____ Sex: M / F

Social Security Number: _____ - _____ - _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

RELATED INFO.

Spouse's Employer: _____

Work Phone: (_____)_____

Is Spouse Retired? Y / N

Date Of Retirement: _____ /_____ /_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship To Patient: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Address: _____

REASON FOR VISIT

Y / N **Is This Related To An Accident?** Date Of Accident: _____ /_____ /_____

Please Describe Accident: _____

Y / N **Is This Work Comp?** Contact Person And Phone Number: _____ (_____)_____

Please Describe Accident: _____

Y / N **Is This Car Insurance?** *Must have a copy of car insurance or name of agent.**

Please Describe Accident: _____

PHARMACY INFORMATION

Name Of Pharmacy: _____ Phone: (_____)_____

City: _____ State: _____

Mail Order Pharmacy: _____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

FOR HOSPITAL USE ONLY:

☐ Short form complete ☐ Consent form signed ☐ Insurance cards copied ☐ ID copied

CONTINUED ON BACK ▶

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PATIENT INFORMATION FORM

FINANCIAL RESPONSIBILITY IF OTHER THAN THE PATIENT

Patient's guarantor is the person financially responsible for payment or the name on billing statement.

Name: _____ Relationship to Patient: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Address: _____

INSURANCE SUBSCRIBER IF OTHER THAN THE PATIENT

Insurance subscriber is the person who carries the insurance.

Subscriber's Name: _____ Subscriber's Social Security Number: _____ - ____ - _____

Subscriber's Birth Date: _____ /_____ /_____ Relationship to Patient: _____

Subscriber's Address: _____ City: _____ State: _____ Zip: _____

How did you discover Doctors Without Delay Walk-In Clinic?

☐ Radio ☐ TV ☐ Mail ☐ Online Other: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

By signing this form, I understand the following:

- I hereby authorize payment directly to Doctors Without Delay Walk-In Clinic for benefits due to me for services rendered by Doctors Without Delay Walk-In Clinic. I understand that I am responsible for charges not covered by this authorization. I hereby authorize release of any information regarding my examination to my insurance company/workman's compensation/laboratory/radiology for billing reasons.
- I understand that there may be times when my healthcare provider orders tests that my insurance may deem unnecessary. I agree to be responsible for these charges.
- I understand that laboratory/radiology charges are separate charges from my healthcare provider's visit. Any questions that I have about laboratory/radiology billing may be addressed to that facility.

Date: _____ /_____ /_____ Signature: _____