GEARY COUNTY HEALTH DEPARTMENT
YOUTH CLINIC
CLIENT REGISTRATION FORM

Last Name: _____ First Name: _____ M.I. _____ Nickname _____

Maiden Name: _____ Marital Status: __ Single __ Married __ Divorced __ Widowed

Birth Date: _____/_____/_____ SS#: _____-____-_____ Sex: __ Female __ Male

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

Home Phone: ____-_____-_____ Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____
May we contact you at the above address for billing details/ appointment reminder cards? ____Yes ____No
May we contact you at the above phone number(s)? ____Yes ____ No
If NO, how may we contact you? _____

RACE: (mark all that apply)
__AS- Asian/Pacific Islander/Other___ CA-White/Caucasian/Mexican/PuertoRican ___ CH-Chinese
__BL-Black or African American ___American Indian/Alaskan Native ___FL-Filipino___HA-Hawaiian
__IN-Native American/Alaska Native ___NW- Other Non-White ___ Unknown/Not Reported

Hispanic/Latino Origin: Yes No
If YES, and client is receiving services, select one of the following:
___ Mexican ___ Cuban ___ Puerto Rican ___ Central/South American ___ Other/Unknown

Primary Type of Health Coverage:
___ Medicaid ___ Other Public Insurance __ Private Insurance ___Military___ No Coverage___ Unknown

If you have No Insurance Coverage, would you like to speak with someone about Medicaid/KanCare today?
___Yes ___No

Income:
Total Household Income: **$_____ per (circle one): Yearly or Monthly**
Number of Persons supported by this income: _____

Guarantor/Head of Household: (if different from above) Responsible party Under 18 yrs if applicable:
Last Name: _____ First Name: _____ Relationship: _____

Address: _____ City _____ State: _____ Zip: _____

Home Phone: ___-___-____ Work Phone: ___-___-____ Cell Phone: ___-___-____

I certify that all the above information is correct to the best of my knowledge.

_____ _____
(Signature of Client) (**Date**)

FOR STAFF USED ONLY

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Annual Income Assessment: _____ Level of Discount: _____
Do you need and Interpreter? ❒ Yes (Bilingual staff/Interpreter Services Used)
❒ No (Speaks/Understands English)

_____ _____
(Signature of Staff) **(Date)**

RV: 08/24/15

Geary County Health Department
1212 West Ash Street, Junction City, KS 66441
Phone (785)762-5788 Fax (785)762-5025

ACKNOWLDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of the Geary County Health Department's Notice of Privacy Practices with the effective date of April 14, 2003.

The staff has explained issues about confidentiality and medical record privacy, and I understand the privacy policies

X _____

_____ _____

Signature of Patient/Client Representative Date

_____

Relationship to Client

Revised: 08/24/2015

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