KERN VALLEY HEALTHCARE DISTRICT
PATIENT INFORMATION FORM

TODAYS DATE_____

FIRST MIDDLE LAST

PATIENT'S NAME_____**DATE OF BIRTH**_____

AGE_____**SOCIAL SECURITY#**_____**Gender: Male Female Other**

MAILING ADDRESS_____**PO BOX**_____

CITY, STATE, ZIP_____

HOME PH_____**CELL**_____**EMAIL** _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED **SMOKER:** Y N FORMER

SPOUSE'S NAME _____**DATE OF BIRTH** _____**PHONE**_____

EMERGENCY
CONTACT NAME_____**RELATIONSHIP**_____**PHONE**_____

Medicare Patients:
Is visit due to an accident? Yes No **If yes please circle one: Auto / WC / Other 3rd party Liability**

EMPLOYMENT STATUS: FT PT SELF EMP UNEMPLOYED RETIRED DISABLED

EMPLOYER_____**PHONE**_____

ADDRESS_____ **CITY, STATE, ZIP**_____

PRIMARY LANGUAGE: ENGLISH SPANISH OTHER_____

RACE (CIRCLE UP TO FIVE): WHITE ASIAN NATIVE HAWAIIAN (OR) PACIFIC ISLANDER OTHER RACE

BLACK (OR) AFRICAN AMERICAN AMERICAN INDIAN (OR) ALASKAN NATIVE UNKNOWN/REFUSED TO REPORT

EHTINICITY (CIRCLE ONE): HISPANIC/ LATINO NOT HISPANIC/LATINO UNKNOWN/REFUSED TO REPORT

IF THE PATIENT IS A CHILD-

MOTHERS NAME_____DOB_____SSN_____

FATHERS NAME_____DOB_____SSN_____

ADDRESS_____CITY_____ST____ZIP_____PHONE_____

PRIMARY INS_____POLICY#_____GROUP#_____

SECONDARY INS_____POLICY#_____GROUP#_____

PRIMARY CARE PHYSICIAN_____

KVH 6018 Revised 6/20 SJ