KC Medical Care

Kelly C. McCants, MD

PATIENT PROFILE

NAME: _____ DATE: _____

PATIENT INFORMATION

Email:

_____

Address:

_____

_____

Cell Phone:_____

Home Phone:_____

Work Phone:

_____

[ ] Male [ ] Female

Date of Birth: _____

Social Security #: _____

[ ] Married [ ] Single [ ] Divorced

Spouse's Name:_____

Spouse's Phone #: _____

Referring Physician: _____

Physician Phone #: _____

PCP: _____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Self Employed

Employer Name: _____

Phone:

_____

PHARMACY INFORMATION

Pharmacy Name:_____

Pharmacy #: _____

GUARANTOR PHONE

Home #: _____

Work #: _____

EMERGENCY CONTACT & PHONE #:

_____

GUARANTOR (Individual signing this form)

[ ] Same as Patient [ ] Other

Name:

_____

Address:

_____

_____

Phone:

_____

PRIMARY INSURANCE

***Secondary Insurance: Please Provide Information to Front Desk**

Policy Holder's Name:_____

Policy Holder's Phone #:_____

Insurance Co:_____

Insurance Co Address:_____

_____

___

Relationship to Patient: _____

Policy Holder's SSN: _____

Insurance ID #: _____

Policy Group: _____

Policy Holder's DOB:_____