

OLATHE MEDICAL CENTER OUTPATIENT REGISTRATION INFORMATION

PATIENT INFORMATION						
Last Name		First Name			Middle Initial	
Address				City	State	Zip
County	Home Phone	Date of Birth	Social Security #	Male / Female	Marital Status	
Religion	Employer	Employer Phone #		Occupation		
Employer Address				Physician		
GUARANTOR (if different than patient)						
Last Name		First Name		Middle Initial	Relationship	
Address				City	State	Zip
County	Home Phone	Date of Birth	Social Security #	Male / Female	Marital Status	
Religion	Employer	Employer Phone #		Occupation		
Employer Address				Physician		
SPOUSE OR PARENT						
Last Name		First Name		Middle Initial	Relationship	
Address				City	State	Zip
County	Home Phone	Date of Birth	Social Security #	Male / Female	Marital Status	
Religion	Employer	Employer Phone #		Occupation		
Employer Address				Physician		
RELATIVE OR FRIEND (Emergency Contact)						
Last Name		First Name		Middle Initial	Relationship	
Home Phone Number						
INSURANCE						
Who Carries Insurance?	Insurance Company			Insurance ID #	Insurance Group #	
Insurance Address (Claims Address)				City	State	Zip
Onset of Symptoms (Date)					Pregnant? Y / N	
ADDITIONAL NOTES:						

FAX THIS TO 913-791-3532.