



**KEWAUNEE COUNTY DEPARTMENT OF HUMAN SERVICES**

810 Lincoln Street

Kewaunee, WI 54216

Phone: (920) 388-7030 Fax: (920) 388-7124

**PATIENT REGISTRATION INFORMATION**

Date: \_\_\_/\_\_\_/\_\_\_

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Maiden Name \_\_\_\_\_ Social Security Number: \_\_\_ - \_\_\_ - \_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Sex:  M  F  Other Marital Status:  Separated  Single  Married  Divorced  Widowed

Primary Language: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Emergency home phone:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Emergency Relationship:** \_\_\_\_\_ **Emergency work phone:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**If you are under 18 years of age, have a legal guardian, or representative payee, please fill out this area:**

Father: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Mother: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Guardian: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Representative Payee: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Who do you live with?  Mother and Father  Father  Mother  Legal Guardian

Other: \_\_\_\_\_ Relationship: \_\_\_\_\_

Student at: \_\_\_\_\_ Grade: \_\_\_\_\_

Referred by: \_\_\_\_\_

Cultural/Spiritual/Religion?  Yes  No If yes, Religion: \_\_\_\_\_

Are you a Veteran?  Yes  No

Are you working with a probation agent?  Yes  No If yes, name of agent: \_\_\_\_\_

**Please check which of the following services you are interested in:**

Operating While Intoxicated (OWI) – Driver's License#: \_\_\_\_\_ County of Conviction: \_\_\_\_\_

Mental Health Counseling

Psychiatrist (Medications)

Alcohol/Other Drug Abuse Counseling (AODA)

Please describe why you are seeking services:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

| Medication | Dosage | Time of Day | Prescribing Doctor |
|------------|--------|-------------|--------------------|
| _____      | _____  | _____       | _____              |
| _____      | _____  | _____       | _____              |
| _____      | _____  | _____       | _____              |

**Allergies:**

| Medication | Adverse Reaction |
|------------|------------------|
| _____      | _____            |
| _____      | _____            |
| _____      | _____            |

**OPTIONAL:**

|                                     |                           |
|-------------------------------------|---------------------------|
| Name of Primary Physician: _____    | Address: _____            |
| Phone #: _____<br>( ) _____ - _____ | Date of Last Visit: _____ |
| Name of Dentist: _____              | Address: _____            |
| Phone #: _____<br>( ) _____ - _____ | Date of Last Visit: _____ |
| Name of Eye Doctor: _____           | Address: _____            |
| Phone #: _____<br>( ) _____ - _____ | Date of Last Visit: _____ |

**INSURANCE INFORMATION (Please provide copy of both sides of insurance cards)**

Insurance Company Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Policy holder name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Does your insurance require you to see certain providers?  Yes  No  
If yes, is Kewaunee County a member of your network?  Yes  No  
Is Prior Authorization required?  Yes  No Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Medical Assistance #: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
VA/Champus#: \_\_\_\_\_ Any other insurance? \_\_\_\_\_  
(If yes, present card/information)  
If a minor, who has legal custody? \_\_\_\_\_

**ONLY IF UNINSURED – Drop off supporting documents or submit to HSclinic@kewauneeco.org**

Gross household income: \$ \_\_\_\_\_ per month  
Unearned income: \$ \_\_\_\_\_ per month (child support received, unemployment, disability, etc.)  
Number of persons, including self, who live on this income: \_\_\_\_\_  
Court ordered obligations: \$ \_\_\_\_\_ per month (child support paid, fines, and probation fees)

**DISCLAIMER AND SIGNATURE**

I certify that my answers are true and complete to the best of my knowledge. I agree to provide any additional information requested by Kewaunee County to determine my right to receive a reduced fee for services.

I authorize payment to the Kewaunee County Department of Human Services of the benefits herein, specified and otherwise payable to me, but not to exceed the Agency's regular charges for this period of treatment. I understand that if I have not provided full insurance, Medical Assistance, Medicare benefit information, I will be liable for the full cost of the services provided.

I authorize the Kewaunee County Department of Human Services to release a copy of any or all of my medical records, including records received from other agencies to my insurance company, Medical Assistance, Medicare Intermediary, the Health Care Financing Administration and its agents, to be used for the sole purpose of securing payment to the Kewaunee County Department of Human Services. I understand that I have a right to inspect and receive a copy of the material disclosed if I request one.

I understand that this consent is revocable at any time and this consent remains in full force until termination of treatment.

Patient Signature: \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_  
(Age 16 or older)

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_

**FOR OFFICE USE ONLY:**

Is the family currently being billed for State or County funded service relating to mental health, AODA, developmental disabilities, social services, youth corrections services?  Yes  No

Medicaid Co-pay: \_\_\_\_\_

Personal liability per month: \_\_\_\_\_

No financial ability to pay: \_\_\_\_\_