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 #: (____) _____- _____
Date of Last Visit: _____

Name of Dentist: _____
Address: _____
Phone #: (____) _____- _____
Date of Last Visit: _____

Name of Eye Doctor: _____
Address: _____
Phone #: (____) _____- _____
Date of Last Visit: _____

HEALTH 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: _____