



HEARTLAND MEDICAL CARE, P.C.
 10010 EAST TRUMAN ROAD
 INDEPENDENCE, MO 64052-2160
 816-252-7800

Thank you for choosing our office. In order to care for you properly, we need the following information.

PLEASE PRINT- All information will be confidential.

Date _____ Patient Name _____ Patient # _____

SSN _____ Male Female Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check appropriate box: Minor Single Married Divorced Widowed Separated

Patient's or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Employer _____ Work phone _____

If patient is a student, name of school/college _____ City _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home Phone _____

Driver's license # _____ Date of birth _____ Financial Institution _____

Employer _____ Work phone _____

Is this person currently a patient at our office? Yes No

Insurance Information

Name of insured _____ Relationship to patient _____

Date of birth _____ SSN _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company| _____ Group# _____ Union or Local # _____

Ins. Co. address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual benefit _____

Do you have additional insurance? Yes No If yes, complete the following

Name of insured _____ Relationship to patient _____

Date of birth _____ SSN _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company| _____ Group# _____ Union or Local # _____

Ins. Co. address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual benefit _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me to be paid directly to the doctor. I have received the Notice of Privacy Practices.

 Signature of patient or parent if patient is a minor

 Date