Mitchell County Health Department
310 W. 8th St Beloit, KS 67420
785-738-5175

Patient Information

Patient Name: _____

Date of Birth: _____ Social Security #: _____

Patient Address: _____

City, State, and Zip Code: _____

Home/Cell phone: _____ **Primary Care Physician**: _____

Subscriber of Insurance

First & Last Name: _____ Date of Birth: _____

Insurance ID#: _____ Group #: _____

Emergency Contact

Full Name: _____

Address: _____

City, State, and Zip Code: _____

Telephone #: _____ **Relationship to patient**: _____

Parent/Guardian Information

Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City, State, and Zip: _____

Home/Cell Phone: _____

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Consent

Release of Information

I authorize the release of information, including, but not limited to, diagnosis, records, examination rendered to me, and claims information to the individual(s) listed below.

Name and Relationship: _____

_____

Consent to Treat a Minor

Are you a parent / guardian filling out information for a minor? Yes ☐ No ☐

If yes, fill out the information below. If no, skip the next section and sign/date at the bottom.

If parents / guardians are unable to bring a minor in for their appointment, you may authorize another individual over the age of 18 to bring them.

I authorize the Mitchell County Health Department to provide services to my son or daughter. The following people have my permission to bring them in for services.

Name and Relationship to Minor: _____

_____

Signature (including relationship): _____

Date: _____