

MEDICAL HISTORY

FILL OUT THIS FORM COMPLETELY. PRINT LEGIBLY. Attach a legible copy of your immunization record. Completion of this is required **before** receiving non-urgent care at Lafene Health Center.

Today's Date:		
Last Name:	First Name:	Middle Initial:
Wildcat ID #:	Date of Birth:	

Email Address:	
Mailing Address:	
Primary Phone Number:	Secondary Phone Number:

CITIZENSHIP: <input type="checkbox"/> US Citizen <input type="checkbox"/> Other Citizen <input type="checkbox"/> Foreign Born List Country: _____	STUDENT STATUS: <input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate Student <input type="checkbox"/> Other Student <input type="checkbox"/> KSU Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Visitor	ETHNICITY: <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____	MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender
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EMERGENCY CONTACT:

Name:	Relationship:	Phone Number:	
Street Address:	City:	State:	Zip Code:

CURRENT INSURANCE INFORMATION:

Please submit by mail or in person to Lafene Health Center, 1105 Sunset Ave, Manhattan KS 66502, one copy of the front and back of each medical and pharmaceutical card for this patient. Please include the following additional information: **Patient's name, Wildcat ID number, Policy Holder's name, Policy Holder's date of birth, Patient's relationship to Policy Holder, Policy Holder's address (including street, city, state and zip) & phone number.**
 If you mail or fax your insurance information, please confirm with the Insurance Department that we did receive your insurance information. It is the patient's responsibility to make sure we receive all necessary insurance information for filing claims. **All insurance claims will be filed with your insurance company unless you request otherwise.** If you have any questions, call our Insurance Department at (785)532-6749. Thank you.

Mark this box if you attended a KANSAS high school.

ALLERGIES or REACTIONS TO MEDICINES, FOODS: (example: penicillin, peanuts, bee stings, latex)

Medications:	Food:
Insect stings:	Other:

CURRENT MEDICATIONS (INCLUDE DOSE & FREQUENCY): Include prescriptions, birth control, over the counter & herbal.

