SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

ADULT PATIENT DEMOGRAPHIC FORM

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Patient's Full Legal Name

Last:	First:	Middle Initial:

Preferred Name/Nickname:	Social Security Number:	Date of Birth:	Sex:
	- -	/ /	☐ Male ☐ Female

Race:
☐ African American/Black ☐ Asian ☐ White
☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska Native ☐ Other _____

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Marital Status:
☐ Single ☐ Married
☐ Divorced ☐ Widowed

Street Address / PO Box:	Lot / Apt #:	City:	State:	Zip Code:

Primary Phone #:	Cell/Mobile?	Secondary Phone #:	Cell/Mobile?
( )	☐ Yes ☐ No	( )	☐ Yes ☐ No

Email Address:	Preferred Language:

How were you referred to or how did you discover KU Wichita MPA Clinics?

Patient Guardian Full Name (If Applicable)	Relationship:	Phone #:	City & State:
		( )	

CURRENT HEALTHCARE PROVIDER INFORMATION

Primary Care Physician/Provider:	Referring Physician/Provider:

Preferred Hospital:	Preferred Pharmacy:

CURRENT EMPLOYMENT/STUDENT STATUS

Employer:	Employment Status:	Student Status:
	☐ FT ☐ PT ☐ Self ☐ Military ☐ Unemployed ☐ Retired ☐ Disabled	☐ FT ☐ PT ☐ Not a Student

Employer Address:	Employer Phone:	Name of School:
	( )	

BILLING/INSURANCE INFORMATION

Primary Health Insurance Company:	Policy Holder Full Name:	Policy Holder Date of Birth:

Secondary Health Insurance Company:	Policy Holder Full Name:	Policy Holder Date of Birth:

HIPAA CONTACTS - AUTHORIZED REPRESENTATIVES

By listing contacts below, you authorize our office to communicate with them regarding your health, treatment, and billing under HIPAA. ☐ No HIPAA Contacts

Name:	Relationship:	Phone #:
Name:	**Relationship:**	**Phone #:**

EMERGENCY CONTACTS

Someone we may contact in an emergency or if you're unreachable, but are not authorized to receive your medical information. ☐ No Emergency Contacts

Primary Emergency Contact Full Name:	Relationship:	Phone #:	City & State:

Signature of Patient, Responsible Party, or Authorized Legal Representative

Date

Printed Name of Patient, Responsible Party, or Authorized Legal Representative

Relationship to Patient

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STAFF/ADULT HISTORY FORM

NAME_____ **DOB**_____ **TODAY'S DATE**_____

Why are you here today? _____

LIST YOUR ILLNESSES, HOSPITALIZATIONS, SURGERIES, AND INJURIES:
Date Reason

_____
_____
_____

LIST YOUR CURRENT MEDICATIONS AND SUPPLEMENTS:
Name of Medicine Strength Directions for use

_____
_____
_____

ANY ALLERGIES (Medications, Food, Etc.)

_____
_____

IMMUNIZATION HISTORY:
Last Tetanus (Td or Tdap) _____ Last Influenza _____
Have you received a Pneumonia vaccine? YES NO Have you received a Shingles vaccine? YES NO

FAMILY HISTORY:
Relationship Age Any Health Problems
Father _____
Mother _____
Sibling(s) _____
Children _____

Has any blood relative ever had?:

Cancer	YES NO	High Blood Pressure	YES NO	Convulsions	YES NO
Tuberculosis	YES NO	Diabetes	YES NO	Emotional Problems	YES NO
Heart Trouble	YES NO	Stroke	YES NO	Substance Abuse	YES NO
Gout/Arthritis	YES NO	Bleeding Tendency	YES NO		

SOCIAL HISTORY (Circle One):
Marital Status: SINGLE MARRIED SEPARATED DIVORCED WIDOWED
Sexual Preference: MALE FEMALE BOTH
Have you been sexually active in the last month? YES NO

How many people live in your household? _____ What form of transportation do you use? _____
Employed outside of the home? YES NO What is your job title? _____
Are you or have you ever been exposed to fumes, dusts, or solvents? YES NO

Do you use tobacco (cigarettes, cigars, pipe, chewing tobacco)? YES NO If no, previous use? YES NO
Amount used (previous or current)? _____ Packs per day
Do you use alcoholic beverages? YES NO Amount used? _____ Drinks per week _____
Have you ever used any of the following? MARIJUANA COCAINE HEROIN METHAMPHETAMINE
OTHER IV DRUGS

SOCIAL HISTORY *Continued* (Circle One):

Seatbelts?	ALWAYS ☐	SOMETIMES ☐	NEVER ☐
Sunscreen?	ALWAYS ☐	SOMETIMES ☐	NEVER ☐
Exercise?	ALWAYS ☐	SOMETIMES ☐	NEVER ☐
Regular Balanced Meals?	ALWAYS ☐	SOMETIMES ☐	NEVER ☐

See a dentist regularly? YES ○ NO ○ Last dentist appointment? _____

See an eye doctor regularly? YES ○ NO ○ Last eye exam? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Recent weight change	YES ○	NO ○	Fast or skipped heartbeat	YES ○	NO ○	Urinating more often	YES ○	NO ○
Skin disease	YES ○	NO ○	Chest pain or heaviness	YES ○	NO ○	Night time urination	YES ○	NO ○
Jaundice (yellow skin)	YES ○	NO ○	Shortness of breath	YES ○	NO ○	Burning/painful urination	YES ○	NO ○
Hives, eczema, rash	YES ○	NO ○	Heart trouble/heart attack	YES ○	NO ○	Blood in urine	YES ○	NO ○
Moles or skin changes	YES ○	NO ○	High blood pressure	YES ○	NO ○	Kidney infection	YES ○	NO ○
Eye problems	YES ○	NO ○	Swelling hands/feet/ankles	YES ○	NO ○	Kidney stones	YES ○	NO ○
Wear glasses	YES ○	NO ○	Heart murmur	YES ○	NO ○	Bladder incontinence	YES ○	NO ○
Double vision	YES ○	NO ○	Blood clots	YES ○	NO ○	Sexually transmitted disease	YES ○	NO ○
Headaches	YES ○	NO ○	Anemia	YES ○	NO ○	Convulsions/seizures	YES ○	NO ○
Nosebleeds	YES ○	NO ○	Peptic ulcer	YES ○	NO ○	Fainting spells	YES ○	NO ○
Sinus trouble	YES ○	NO ○	Vomiting	YES ○	NO ○	Shaking or trembling	YES ○	NO ○
Ear problems	YES ○	NO ○	Gallbladder disease	YES ○	NO ○	Muscle weakness	YES ○	NO ○
Hearing loss	YES ○	NO ○	Liver disease	YES ○	NO ○	Stiff or painful joints	YES ○	NO ○
Dizziness	YES ○	NO ○	Hepatitis	YES ○	NO ○	Hot or cold flashes	YES ○	NO ○
Difficulty swallowing	YES ○	NO ○	Blood in stool	YES ○	NO ○	Difficulty making decisions	YES ○	NO ○
Neck stiffness	YES ○	NO ○	Black stool	YES ○	NO ○	Memory loss	YES ○	NO ○
Thyroid disease	YES ○	NO ○	Change in bowel habits	YES ○	NO ○	Difficulty relaxing	YES ○	NO ○
Swollen glands	YES ○	NO ○	Diarrhea	YES ○	NO ○	Do you lose your temper often	YES ○	NO ○
Coughing	YES ○	NO ○	Heartburn/indigestion	YES ○	NO ○	Are you having sexual problems	YES ○	NO ○
Asthma/wheezing	YES ○	NO ○	Abdominal pain	YES ○	NO ○	Do you feel lonely or depressed	YES ○	NO ○
Problems breathing	YES ○	NO ○	Trouble sleeping	YES ○	NO ○	Have you ever considered suicide	YES ○	NO ○
Lung disease	YES ○	NO ○	Feel tired most of the time	YES ○	NO ○	Panic or anxiety attacks	YES ○	NO ○

Do you consider your health (circle one): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

FOR MEN ONLY:

Last testicular exam _____ Last prostate exam _____

FOR WOMEN ONLY:

Age menstrual cycles began _____
How often are periods? Every_____ days
How long do periods last? _____days
How long do periods last? _____days
How long do periods last? _____days
Date of last period _____
Vaginal discharge YES ○ NO ○

Last mammogram (breast exam) _____
Breast lump or nipple discharge YES ○ NO ○

Last pap smear & results _____
Number of pregnancies _____
Number of miscarriages/abortions _____
Have you ever had a DEXA scan? YES ○ NO ○
If so, when was your last one? _____

REVIEW:

Signature _____ Date _____

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NEW PATIENT OUTPATIENT CONSENT FORM
Consent for Treatment, Telehealth & AI Dictation

CONSENT FOR OUTPATIENT TREATMENT

I voluntarily consent to receive outpatient healthcare services at UKSM-W Medical Practice Association, including evaluation, diagnosis, and treatment by licensed healthcare physician and providers. I understand I have the right to be informed about my treatment, including potential risks and alternatives, and may withdraw this consent at any time in writing. This consent remains valid for the duration of my care unless revoked.

INFORMED CONSENT FOR TELEHEATH SERVICES

I authorize the use of telehealth technology for remote evaluations and treatment.

- I may be seen via video or audio-only communication, depending on clinical need and technology availability.
- I understand that technical issues may delay care.
- Privacy laws, including HIPAA, apply to all telehealth services.
- My physician and provider will not record the session without my consent, and my information will not be shared with third parties without authorization.
- I may withdraw this consent at any time without affecting my right to future care.
- I understand my insurance may not fully cover telehealth visits and I may be responsible for uncovered charges.
- Telehealth may involve the transmission of my medical information across state or regional networks using secure platforms with encryption and privacy protections.

USE OF ARTIFICIAL INTELLIGENCE (AI) DICTATION TECHNOLOGY

To support accurate and efficient documentation of your care, our clinic uses HIPAA-compliant, AI-powered dictation technology to transcribe verbal information into text for inclusion in your medical record. By signing this consent to treatment, you acknowledge and understand the following:

- AI may be used to transcribe verbal information into text for efficiency and accuracy in my medical record.
- Audio input used for AI transcription is deleted within 7 days. AI is not used to make clinical decisions.
- My physician and provider will personally review and confirm all AI-dictated content before it becomes part of my official medical record.
- Security protocols including encryption and access control protect the confidentiality of my information.
- I may request access to or corrections of my records at any time.

YOUR RIGHT TO OPT-OUT OF AI DICTATION TECHNOLOGY

You have the right to decline the use of AI dictation during your visit. If you choose to opt out:

- Please notify your physician and provider or clinic staff before your appointment begins.
- Your physician and provider will document your visit using traditional methods.
- You acknowledge that opting out may result in longer documentation times and may affect the efficiency of your visit.

VALUABLES

I understand that UKSM-W Medical Practice Association is not responsible for any personal valuables that are lost, stolen, or damaged while I am on clinic premises. I am advised not to bring valuables to appointments.

PATIENT ACKNOWLEDGMENT

By signing below, I confirm that I have read and understand this consent form. I have had the opportunity to ask questions, and all concerns have been addressed to my satisfaction. I voluntarily agree to the above terms.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

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CONSENT TO COMMUNICATE ELECTRONICALLY

What types of communication could be sent to me?

University of Kansas School of Medicine – Wichita Medical Practice Association "UKSM-W MPA" may send messages regarding your care, such as:

- Appointment reminders and scheduling updates
- Billing and payment notices
- Health-related information or education
- Feedback requests about your visit or services

How might I receive communications?

You may receive communications through one or more of the following:

- Email Notifications
- Text message (SMS)
- Phone or Voice over Internet Protocol (VoIP).

Some messages may be sent using automated dialing systems or include prerecorded/artificial voice.

Will the communications be secure?

Most emails will be encrypted. However, some emails or text messages containing limited personal information may not be encrypted and could pose a security risk. While the likelihood of interception is low, unencrypted messages may be accessed by unauthorized parties. By consenting to electronic communication, you acknowledge and accept this risk. UKSM-W MPA will take reasonable steps to protect your information but cannot guarantee complete security of unencrypted messages.

Are there any costs to me?

Standard text messaging or data rates may apply depending on your mobile plan. Please contact your wireless carrier for details.

What if I do not want to receive these communications?

You are not required to consent to receive electronic communications. You may opt out at any time by:

- Replying "STOP" to any text message
- Clicking "Unsubscribe" on any email
- Contacting your UKSM-W MPA clinic directly

Your preferences will remain in effect unless you update them or give a different type of consent for a specific clinic service or communication platform (such as a patient portal).

Consent Options (Select One):

☐ **I ACCEPT** – I consent to receive electronic communications from UKSM-W Medical Practice Association.

☐ **I DECLINE** – I do not wish to receive electronic communications at this time.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

SCHOOL OF MEDICINE WICHITA
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ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

As a patient of UKSM-W Medical Practice Association (MPA), you have the right:

- To be treated with respect, dignity, consideration, and compassion.
- To receive services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical or mental ability.
- To participate in creating a care plan and in making decisions that affects your care.
- To be informed about services and options available to you, including the cost.
- To have your personal information and medical records be treated confidentially.
- To communicate in a language you can understand.
- To consent or refuse to participate in any proposed research study without retribution or difference in the quality of your care.
- To file a grievance about services you are receiving or denial of services.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

PATIENT RESPONSIBILITIES

As a patient of UKSM-W MPA, you have the responsibility:

- To treat other patients and staff of this clinic with respect and courtesy.
- To protect the confidentiality of other patients you encounter in this clinic.
- To participate as much as you are able in creating a care plan, asking questions until you fully understand your care plan, and participating in decision-making that affects your care.
- To let your physician and provider/care team know any concerns you may have about your care plan or changes in your needs.
- To make and keep appointments to the best of your ability, or if possible, to call to cancel or change an appointment time.
- To keep clinic informed of changes in your personal information, including address, phone number, or insurance to ensure timely processing of bills and to promptly meet your financial obligations.
- To provide accurate information to your physician and provider/care team about your symptoms, past illnesses, hospitalizations, medications, and behaviors that may affect your health.
- To follow your care plan and tell physicians and nurses about any obstacles you may encounter in continuing your care plan.
- To consent to a blood test if any healthcare worker should come in contact with your blood.
- To follow clinic rules, such as our no-smoking policy and clinic expectations for patient and visitor behavior, which includes refraining from the use of profanity; verbally abusive, offensive, and/or sexually suggestive language; threatening statements or any act or threat of inappropriate behavior.

I acknowledge that I have reviewed and understand these rights and responsibilities, and I understand that my signature below means that I am agreeing to do my part to respect the clinic's policies and to help create a safe, healing environment. I understand that failure to comply with the terms of this Agreement may prevent me from continuing to receive care from the clinic.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

SCHOOL-BASED HEALTH CARE
AUTHORIZATION FOR BILLING AND HEALTH INFORMATION RELEASE

CONSENT TO BILL INSURANCE AND RESPONSIBLE PARTY

I understand that the health clinic needs to cover its expenses and therefore bills for services rendered. This includes billing third parties such as any applicable health insurer. I further understand that that I, as the patient or the responsible party for the patient, will be billed directly for health services provided by KU Wichita Pediatric / School-Based Health Care that are not covered by my insurer.

I agree to pay and assume all responsibility for medical and hospital expenses and any emergency services incurred not covered by my insurance. UKSM Wichita Medical Practice Association will produce a "Good Faith Estimate" if requested by the self-pay patient/guardian. Good Faith Estimates provide a quote for the cost of treatment prior to services being performed. Patient may authorize the physician and provider to proceed or halt treatment based upon their current financial situation. Additional details of the No Surprises Act can be provided to the patient upon request.

Patient statements will be generated after UKSM Wichita Medical Practice Association has received payment from your insurance company. Methods of communication, including but not limited to, email and text messages, may be used to contact a patient regarding their balance. Patients are automatically opted-in for voice messages, text messages, and email reminders regarding their balance. To opt-out, please provide verbal or written notice to a UKSM Wichita Medical Practice Association receptionist or the business office. If I have concerns regarding billing, I understand that I should contact KU Wichita Medical Practice Association at (316) 293-3429 and not KU Wichita Pediatric / School-Based Health Care or the school where health services were provided.

CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes release of medical information. This information may be shared for:
(1) the patient's treatment, including disclosure to school personnel involved in a student's health care—including but not limited to the school nurse, health aide, social worker, counselor, and mental health care provider on campus—to the extent required to provide quality, comprehensive medical care. For adult patients health information will not be disclosed to school personnel unless specifically authorized by the patient or permitted by law; and
(2) for billing and payment purposes.

I acknowledge I have received a copy of KU Wichita Medical Practice Association's Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that KU Wichita Medical Practice Association may change its privacy practices in the future, and that I may request a copy of the new privacy practices at any time. I also understand that I can contact KU Wichita Medical Practice Association's Privacy Officer with any questions I may have about the Notice of Privacy Practices.

In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of the patient's health information for the purposes described in the Notice of Privacy Practices. In addition to the above, information about the patient may be shared as part of reporting child or adult abuse and/or neglect or other exceptions included in Kansas law.

CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the consent for release of health information. My signature indicates my consent to release medical information as specified.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature (student if 18 years or older or otherwise permitted by law) _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

SCHOOL-BASED HEALTH CARE
ACKNOWLEDGEMENT OF POLICIES

University of Kansas School of Medicine – Wichita Medical Practice Association ("MPA") has made updates to the following policies:

- **Notice of Privacy Practices** - *Revised December 2025*
- **Notice of Non-Discrimination** - *Revised December 2025*

Printed copies of each policy are available upon request at the front desk. Please sign below to acknowledge that you have been informed of these policy updates and have had the opportunity to review or request a copy.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature (student if 18 years or older or otherwise permitted by law) _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____