YELM FAMILY MEDICINE – PATIENT INFORMATION

PATIENT NAME_____
(First) (Middle) (Last)

BIRTHDATE_____SEX ___ Male___Female SSN_____

MAILING ADDRESS_____

EMAIL ADDRESS_____

CITY, STATE, ZIP _____

HOME PHONE _____WORK PHONE_____
(Area Code) (Area Code)

EMPLOYER_____CELL PHONE_____
(Area Code)

****Marital Status
__Single
__Married
__Widowed
__Separated

***Race(Govt Req)
Caucasian_____
Black _____
Hispanic_____
Asian_____
OTHER_____
REFUSED____

*****ETHNICITY: Latino/Hispanic __OTHER__Not Reported/Refused____ (GOVERNMENT REQUIRED)

****SPOUSE, PARENT, GUARDIAN INFORMATION – Same Household****

FULL NAME_____

ADDRESS (If different)_____

RELATIONSHIP TO PATIENT ___Spouse ___Parent ____Guardian ___Other_____

BIRTHDATE_____SSN_____WORKPHONE_____
(AREA CODE)

EMPLOYER BUSINESS NAME_____

****INSURANCE INFORMATION – We need current copy of card on file****

INSURANCE NAME_____PHONE_____
(AREA CODE)

SUBSCRIBER'S NAME____ _____D.O.B._____COPAY$_____

SUBSCRIBER'S EMPLOYER_____

ID#_____GROUP#_____DEDUCTIBLE$_____

****SECONDARY INSURANCE – We need current copy of card on file****

INSURANCE NAME_____PHONE_____
(AREA CODE)

SUBSCRIBER'S EMPLOYER_____

ID#_____GROUP#_____DEDUCTIBLE$_____

EMERGENCY CONTACT INFORMATION (Someone not living with you)*

Name_____PH#_____RELATION_____
(AREA CODE)

Name_____PH#_____RELATION_____
(AREA CODE)

TODAY'S DATE_____ UPDATED_____