

**YELM FAMILY MEDICINE – PATIENT INFORMATION**

PATIENT NAME \_\_\_\_\_

(First) (Middle) (Last)

BIRTHDATE \_\_\_\_\_ SEX \_\_\_ Male \_\_\_ Female SSN \_\_\_\_\_

**\*\*\*\*Marital Status**

MAILING ADDRESS \_\_\_\_\_  Single

Married

EMAIL ADDRESS \_\_\_\_\_  Widowed

Separated

CITY, STATE, ZIP \_\_\_\_\_

**\*\*\*Race(Govt Req)**

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

(Area Code)

(Area Code)

Caucasian \_\_\_\_\_

Black \_\_\_\_\_

Hispanic \_\_\_\_\_

EMPLOYER \_\_\_\_\_ CELL PHONE \_\_\_\_\_

(Area Code)

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** \_\_\_\_\_