FAMILY DOC'S CLINIC

BOARD CERTIFIED IN FAMILY PRACTICE
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PATIENT INFORMATION

Date:___/___/___ **Patient Name:** _____ **Birth Date:** ___/___/___

SS #_____ **Sex:** M___ F___ **Marital Status:** Single___ Married___ Domestic Partner___ Widow___

Spouse's Name:_____

If Minor, Custodial Parents/Guardians Name(s): _____

Home Address: _____ **City:**_____ **State:**____ **Zip:**_____

Is Billing Address the Same as Home Address? Yes___ No___ If no, enter below:

Billing Address:_____ City:_____ State:____ Zip:_____

Home Phone: ( ) _____-_____ **Cell Phone:** ( ) _____-_____

Work Phone: ( ) _____-_____ ext. _____ **Email:** _____

Contact Preference: Mail___ Home Phone___ Cell Phone___ Work Phone___

Employed___ Unemployed___ Retired___ Disabled ___ F-T Student___ P-T Student___

Employer: _____

Language/Communication Preference if not English: _____

Ethnicity:
- Hispanic or Latino___
- Not Hispanic or Latino___
- Prefer Not to Answer___

Race:
- American Indian or Alaska Native___
- Native Hawaiian or Other Pacific Islander___
- White or Caucasian___
- Other Race___
- Prefer Not to Answer___

Sexual Orientation:
- Lesbian, Gay, or Homosexual___
- Straight or Heterosexual___
- Bisexual___
- Don't know___
- Choose not to disclose___

Gender Identity:
- Identifies as Male___
- Identifies as Female___
- Transgender Male (FTM)___
- Transgender Female (MTF)___
- Choose not to disclose___

Assigned Gender at Birth:
- Male___
- Female___
- Choose not to disclose___

Pronouns:
- He/Him___
- She/Her___
- They/Them___

CONTACTS IN CASE OF EMERGENCY

Name: _____

Phone: ( ) _____-_____ Relationship to Patient: _____

Name: _____

Phone: ( ) _____-_____ Relationship to Patient: _____

PREFERRED PHARMACY

Local Pharmacy Name: _____ Phone: _____

Mail Order Pharmacy Name: _____ Phone: _____

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policy, payment is expected at the time services are rendered. Knowledge of insurance deductibles and co-payments are the patient's responsibility. **You will be responsible for your part of the charges at each visit, unless arrangements are made in advance. We accept cash, check, American Express, Discover, MasterCard, and Visa for your convenience.** Your signature below indicates that you understand and accept this policy.

_____ _____

Signature of Patient or Legal Guardian Date