FAMILY DOC'S CLINIC

BOARD CERTIFIED IN FAMILY PRACTICE

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PATIENT INFORMATION

Patient Name: Marital Status: Never Been Married Divorced Domestic Partner Widow Sexual Orientation: Male Female Circle One: L G B T Previous/Maiden Name(s): Spouse's Name: Spouse's Name: If Minor, Custodial Parents/Guardians Name(s): Spouse's Name: If Minor, Custodial Parents/Guardians Name(s): State: Zip: State: Zip	Today's Date:	SS#:
Sex: M F Marital Status: Never Been Married Married Divorced Domestic Partner Widow Sexual Orientation: Male Female Circle One: L G B T Previous/Maiden Name(s): Spouse's Name: If Minor, Custodial Parents/Guardians Name(s): Home Address:	Patient Name:	Birth Date:\
Domestic Partner	Sex: M F Marital St	atus: Never Been Married Married Divorced
Previous/Maiden Name(s): Spouse's Name: Spouse's Name: Spouse's Name: Spouse's Name: State: Zip: Zip: Zip: State: Zip: Zip: Zip: Zip: Zip: Zip:		
Previous/Maiden Name(s): Spouse's Name:	Sexual Orientation: Male Fem	
If Minor, Custodial Parents/Guardians Name(s): Home Address:	Previous/Maiden Name(s):	Spouse's Name:
State:	If Minor, Custodial Parents/Guard	ians Name(s):
City: State: Zip: If no, enter below Billing Address the Same as Home Address?-Yes No If no, enter below Billing Address: State: Zip: Cell Phone: () Ext Work Phone: () Ext Email: Contact Preference: Mail Home Phone Cell Phone Work Phone Employed Unemployed Retired Disabled F-T Student P-T Student Employer: Ethnicity:	Home Address:	
Is Billing Address the Same as Home Address?-Yes No If no, enter below Billing Address: State: Zip: City: State: Zip: Work Phone: () Ext Email: Contact Preference: Mail Home Phone Cell Phone Work Phone Employed Unemployed Retired Disabled F-T Student P-T Student Employer: Race: American Indian or Alaska Native Native Hawaiian or Other Pacific Islander White or Caucasian Black or African American Other Race Prefer Not to Answer Black or African American Other Race Prefer Not to Answer Eaglish: CONTACT Name: Phone: () Relationship to Patient: Phone: Prefer DPHARMACY Local Pharmacy Name: Phone:	City:	State: Zip:
Billing Address:	Is Billing Address the Same as Ho	me Address?-YesNo If no, enter below
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PREFERRED PHARMACY Local Pharmacy Name: Phone:	Phone: ()	Relationship to Patient:
	Local Pharmacy Name:	Phone:

FIRST INSURANCE INFORMATION

Card Holder's Information: Birth Date: Name: Sex: M___F__ Relationship to Patient: _____ Employer: ______Name of Insurance: _______ Marital Status: Never Bosa Married Married 13 vorced SECONDARY INSURANCE INFORMATION Sexual Orientation: Male__Female__ Circle One: U. G. B. Card Holder's Information: Name: _____ Birth Date: Birth Date: SS#: _____ Sex: M__ F__ Relationship to Patient: _____ Name of Insurance: Employer: THIRD INSURANCE INFORMATION Card Holder's Information: Name: ______ Birth Date: ________ SS#: _____ Sex: M___F__ Relationship to Patient: _____ 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. adelland ton Date as raised not as increased Assengand Signature of Patient or Legal Guardian MEDICAL INFORMATION IN CASE OF EMERGENCY