United Family Medicine
A COMMUNITY CLINIC

Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____

Check Appropriate Box Sig Other Single Married Divorced Widowed Separated

Patient or parent's employer _____ Work phone _____

Full-time/Part-time/Self-Employed _____ Race _____ Ethnicity _____ Country Of Orgin _____

Emergency Contact _____ Phone _____ Secondary Ph: _____

Whom may we thank for referring you _____

Permission to search for Electronic Medical Record _____ _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Cell Phone # _____ Birth Date _____ Soc. Security # _____

Is this person currently a patient in our office Yes No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ _____

Name of employer _____ _____ _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

How much is your co-pay? _____ _____ _____

Do you have any additional insurance Yes No If yes, complete the following:

Name of insured _____ Soc. Security # _____ _____

Name of employer _____ _____ _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Ins. Co. address _____ City _____ State. _____ Zip _____

How much is your co-pay? _____ _____ _____

X _____ _____

Signature of patient (or parent, if minor) **Date**