PARKLAND FAMILY HEALTH CENTER

PATIENT INFORMATION:

NAME:_____DATE OF BIRTH_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE:_____CELL PHONE_____

SOCIAL SECURITY #_____MARITAL STATUS: M S W D

PATIENT EMPLOYER INFORMATION:

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

EMPLOYER PHONE #:_____OCCUPATION:_____

SPOUSE'S INFORMATION:

SPOUSE'S NAME:_____DATE OF BIRTH_____

EMPLOYER NAME:_____

PATIENT SIGNATURE OR AUTHORIZED PERSON_____

DATE_____/_____/_____

RESPONSIBLE PARTY OTHER THAN PATIENT:

PLEASE COMPLETE IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT:

NAME_____DATE OF BIRTH_____

ADDRESS_____

PHONE #_____RELATIONSHIP TO PATIENT_____

FEDERAL LAW REQUIRES US TO DOCUMENT ETHNICITY

(CIRCLE ONE)

ASIAN - AMERICAN INDIAN OR NATIVE ALASKAN - AFRICAN AMERICAN OR BLACK

HISPANIC - NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER - OTHER RACE - WHITE