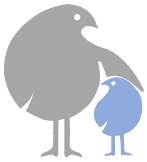

Texas Family Clinic

DEMOGRAPHICS INFORMATION

FIRST AND LAST NAME_____

DATE OF BIRTH _____AGE_____ RACE_____

MARRIED, SINGLE, WIDOWED_____

ADDRESS_____

HOME#_____CELL#_____WORK#_____

PHARMACY_____

EMAIL ADDRESS_____

PRIMARY INSURANCE_____ID #_____GROUP #_____

SECONDARY INSURANCE_____ ID_____ GROUP #_____

POLICYHOLDER NAME _____ ID NUMBER_____

POLICYHOLDER DOB_____

POLICYHOLDER ADDRESS_____

POLICYHOLDER PHONE NUMBER_____

OCCUPATION_____

EMPLOYER NAME _____

EMPLOYER PHONE NUMBER AND ADDRESS_____

PLEASE PROVIDE TWO PEOPLE TO CONTACT IN CASE OF AN EMERGENCY

EMERGENCY CONTACT NAME_____

RELATIONSHIP TO PATIENT_____

EMERGENCY CONTACT PHONE NUMBER_____

EMERGENCY CONTACT NAME_____

RELATIONSHIP TO PATIENT_____

EMERGENCY CONTACT PHONE NUMBER_____

Texas Family Clinic

PLEASE LIST NAME, PHONE NUMBER AND ADDRESS OF PEOPLE YOU GIVE PERMISSION FOR TEXAS FAMILY CLINIC TO DISCLOSE OR DISCUSS YOUR MEDICAL INFORMATION (IE LAB RESULTS,IMAGING RESULTS, MEDICAL DIAGNOSIS ETC) WITH :

1) NAME_____PHONE NUMBER_____

ADDRESS_____

RELATIONSHIP TO PATIENT_____

2 NAME_____PHONE NUMBER_____

ADDRESS_____

RELATIONSHIP TO PATIENT_____

_____ _____

Patient, or caregiver (if patient is a minor , or unable to sign) Relationship to patient(self ,caregiver)

signature

_____ _____

Print name DATE