

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 _____

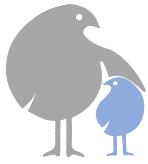
RELATIONSHIP TO PATIENT _____

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 _____

PARENTS PLEASE LIST THE NAME,PHONE NUMBER, AND ADDRESS OF 2 ADULTS THAT YOU GIVE PERMISSION TO ACCOMPANY YOUR CHILD TO APPOINTMENTS AT TEXAS FAMILY CLINIC:

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