DocCare
MEDICAL CLINIC

# PATIENT INFORMATION

First Name _____ Last Name _____

DOB _____ Gender ____M _____F Social Security_____

____ Married____ Single___ Widowed _____Divorced / ____ Employed____ Retired____ Unemployed

Address _____

Home Phone _____ Cell _____ Work _____

Email Address _____

ETHNICITY _____Not Hispanic/Latino _____Hispanic/ Latino _____ Refused

RACE ____American India/ Alaska Native ____Asian ____White ____Black/African American

____Native Hawaiian/Other Pacific Islander _____Other _____Other Specified _____

Preferred Language _____

Emergency Contact _____ Relationship_____

Home Ph # _____ Work Ph # _____

Is the patient the financially responsible party? _____ Y _____ N

If No, indicate name of person who is _____ Relationship _____

Primary Insurance:

First Name _____ Last Name _____

Insurance Company _____ Insured's DOB _____

ID# _____ Group# _____ Phone# _____

Secondary Insurance Information:

Insurance Company _____ Insured's DOB _____

Insurance/ Card Holder's Name _____ Relationship _____

ID# _____ Group# _____ Phone# _____

Patient Signature/Responsible Party _____ Date _____