

AMARILLO FAMILY PHYSICIANS CLINIC, P.A.

MEDICAL RECORD # _____ DATE _____

PATIENT INFORMATION

SOCIAL SECURITY # _____--____--_____ DATE OF BIRTH ____/____/____

LAST NAME _____ FIRST/MIDDLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # _____ WORK PHONE # _____ CELL# _____

SEX M F EMAIL ADDRESS _____

PATIENT EMPLOYER _____ HOW LONG EMPLOYED _____

DOCTOR: BRAVO BRISTER BRITTEN BRYAN CALDWELL CARRUTH
HALE MALONE SPURLOCK STEVENS TYSON WHELCHER

MARITAL STATUS: S M D W

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

HAVE YOU BEEN SEEN IN THIS CLINIC BEFORE? Y N IF YES, WHEN? _____

FAMILY INFORMATION

IN THE COMPUTER WE LINK FAMILY MEMBERS TOGETHER IN ONE FAMILY ACCOUNT, PLEASE LIST OTHER IMMEDIATE FAMILY MEMBERS THAT ARE PATIENTS HERE:

IF PATIENT IS A MINOR

MOTHER _____ FATHER _____

INSURANCE INFORMATION (PLEASE PRESENT YOUR CARD)

PRIMARY INSURANCE _____

CARDHOLDER'S NAME _____ SOCIAL SECURITY # _____

RELATIONSHIP OF CARDHOLDER TO PATIENT: SELF SPOUSE CHILD

IS CARDHOLDER A PATIENT AT THIS CLINIC? Y N

SECONDARY INSURANCE _____

CARDHOLDER'S NAME _____ SOCIAL SECURITY # _____

PATIENT SIGNATURE