

# AMARILLO FAMILY PHYSICIANS CLINIC, P.A.

MEDICAL RECORD # \_\_\_\_\_

DATE \_\_\_\_\_

## PATIENT INFORMATION

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST/MIDDLE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_ CELL # \_\_\_\_\_

SEX M F EMAIL ADDRESS \_\_\_\_\_

PATIENT EMPLOYER \_\_\_\_\_ HOW LONG EMPLOYED \_\_\_\_\_

DOCTOR: ALLMAN BRAVO BRISTER BRITTEN BRYAN CALDWELL

LEAKE 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 # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

CARDHOLDER D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

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