Clinic Patient Information Record

Patient Name/Last: First: Middle: SSN:

Residence Address: City: State: Zip:

Mailing Address: (Check here if same as above) ☐

Home Telephone Number: Cell Phone Number: Email Address:

Date of Birth/Month: Day: Year: ☐ Male ☐ Female Race: Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employer's Name: Work Telephone Number: Ext:

Preferred Language: ☐ English ☐ Spanish ☐ Other Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Communication Needs

Responsible Party: (check here if same as above) ☐

Name/Last: First: Middle: Responsible party's SSN: Date of birth:

Mailing Address: City: State: Zip:

Home Telephone Number: Relationship to Patient:

Employer's Name: Work Telephone Number: Ext:

Responsible Party's Spouse's Name (if applicable): SSN:

In Case of an Emergency, who may we notify (other than someone living with you) Relationship to Patient:

Name: Telephone Number:

Address: City: State: Zip:

Who referred you to our office? Telephone Number:

Is your Illness/injury due to an Auto/Work Accident? Yes ☐ No ☐

Primary Care Physician: _____

I am requesting my Quick Care records from today's visit be sent to my PCP. By signing below, I'm giving permission for Quick Care to send my records to the physician I listed above.

Patient Signature: _____ Date: _____

WILLIS-KNIGHTON QUICK CARE