WILLIS-KNIGHTON HEALTH SYSTEM

# 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: | Date of Birth: | Telephone Number: | | |
| Address: | City: | State: | Zip: | |
| Who referred you to our office? | Telephone Number: | | | |
| **Insurance Coverage** | Is your Illness/injury due to an Auto/Work Accident? Yes ☐ No ☐ | | | |
| Insurance #1 Name of Insurance Company: | | | | |
| Policy Number | Group Number: | | | |
| Employer: | Guarantor: | | | |
| Insurance # 2 Name of Insurance Company: | | | | |
| Policy Number | Group Number: | | | |
| Employer: | Guarantor: | | | |
| Insurance # 3 Name of Insurance Company: | | | | |
| Policy Number | Group Number: | | | |
| Employer: | Guarantor: | | | |
| Preferred Pharmacies: | | | | |



FS0005