John A. Martin Primary Health Care Center

PATIENT INFORMATION

(Please Print)

FOR OFFICE USE ONLY – Patient Chart Number:	Date:

PATIENT INFORMATION

Last Name:	First:	Middle:	Suffix:	If Child: Mothers Name: Fathers Name:

Social Security Number:	Birth Date: _____/_____/_____	Age	Sex: □M □F	Marital Status (circle one) Single / Married / Divorced Separated / Widowed

Race: □White □Black □Asian □Indian/Alaska Native □Pacific Islander □Other □Declined

Ethnicity: □Hispanic □Non-Hispanic

Street Address:	Apt. No.	Home Phone Number: ( )	Cell Phone Number: ( )

P.O. Box:	City:	State:	Zip Code:

Occupation:	Employer or School Name:	Work Phone Number: ( )

Other family members seen here:	Preferred language spoken:

What is your preferred method for us to send reminders to you? □Email □Phone □Letters	Email address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance:	Subscriber's Name:	Group Number:	Policy Number:	Sex: □M □F

Relationship to Insured: □Self □Spouse □Child □Other	Is this person a patient here? □Yes □No	Insured SS Number:	Birth Date: _____/_____/_____

Insured Last Name:	First Name:	Middle Initial:	Insured Social Security Number:

Occupation:	Employer:	Employer Address:	Employer Phone Number: ( )

Name of secondary insurance (if applicable):	Subscriber's Name:	Group Number:	Policy Number:

Insured Last Name:	First Name:	Middle Initial:	Insured's Social Security Number:

Birth Date: ___/___/_____	Sex: □M □F	

IN CASE OF EMERGENCY

Name of local relative or friend (not living at same address):	Relationship to Patient:	Home Phone: ( ) Work Number: ( ) Cell Number: ( )

Address:	City:	State:	Zip: