

YELM FAMILY MEDICINE – PATIENT INFORMATION

PATIENT NAME _____

(First) (Middle) (Last)
BIRTHDATE _____ SEX ___ Male ___ Female SSN _____

MAILING ADDRESS _____ ****Marital Status

PHYSICAL ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE _____ WORK PHONE _____
(Area Code) (Area Code)

EMPLOYER BUSINESS NAME _____

******SPOUSE, PARENT, GUARDIAN INFORMATION – Same Household******

FULL NAME _____

ADDRESS (If different) _____

RELATIONSHIP TO PATIENT ___ Spouse ___ Parent ___ Guardian ___ Other _____

BIRTHDATE _____ SSN _____ WORKPHONE _____
(AREA CODE)

EMPLOYER BUSINESS NAME _____

******INSURANCE INFORMATION – We need current copy of card on file******

INSURANCE NAME _____ PHONE _____
(AREA CODE)

SUBSCRIBER'S NAME _____ D.O.B. _____ COPAY\$ _____

SUBSCRIBER'S EMPLOYER _____

ID# _____ GROUP# _____ DEDUCTIBLE\$ _____

******SECONDARY INSURANCE – We need current copy of card on file******

INSURANCE NAME _____ PHONE _____
(AREA CODE)

SUBSCRIBER'S EMPLOYER _____

ID# _____ GROUP# _____ DEDUCTIBLE\$ _____

*****EMERGENCY CONTACT INFORMATION (Someone not living with you)*****

Name _____ PH# _____ RELATION _____
(AREA CODE)

Name _____ PH# _____ RELATION _____
(AREA CODE)

TODAY'S DATE _____ **UPDATED** _____

