INFANTS' & CHILDREN'S CLINIC, P.C. PATIENT INFORMATION FORM

Please list all patients currently in our practice.

Date: _____

1. **Patient's Last Name:** _____ **First:** _____ **MI:** _____ **DOB:** _____ **Sex:** _____ **Social Security#:** _____

Race: ( ) Asian ( ) Black/African American ( ) White (origin of Europe, the Middle East, or North African)
( ) Hispanic/Latino ( ) American Indian/Alaska Native ( ) Native Hawaiian/Other Pacific Islander

Ethnicity: ( ) Hispanic ( ) Not Hispanic **Language: ( )** English ( ) Spanish ( ) Other _____

2. **Patient's Last Name:** _____ **First:** _____ **MI:** _____ **DOB:** _____ **Sex:** _____ **Social Security#:** _____

Race: ( ) Asian ( ) Black/African American ( ) White (origin of Europe, the Middle East, or North African)
( ) Hispanic/Latino ( ) American Indian/Alaska Native ( ) Native Hawaiian/Other Pacific Islander

Ethnicity: ( ) Hispanic ( ) Not Hispanic **Language: ( )** English ( ) Spanish ( ) Other _____

3. **Patient's Last Name:** _____ **First:** _____ **MI:** _____ **DOB:** _____ **Sex:** _____ **Social Security#:** _____

Race: ( ) Asian ( ) Black/African American ( ) White (origin of Europe, the Middle East, or North African)
( ) Hispanic/Latino ( ) American Indian/Alaska Native ( ) Native Hawaiian/Other Pacific Islander

Ethnicity: ( ) Hispanic ( ) Not Hispanic **Language: ( )** English ( ) Spanish ( ) Other _____

Primary Guardian's Name: _____ **Relationship to Patient:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____ **Cell: (_____)** _____ **Email:** _____

Social Security #: _____ **DOB:** _____

Work Phone:(_____) _____ **Place of Employment:** _____

Other Guardian's Name: _____ **Relationship to Patient:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____ **Cell: (_____)** _____ **Email:** _____

Social Security #: _____ **DOB:** _____

Work Phone:(_____) _____ **Place of Employment:** _____

Preferred Contact Method: ( ) Phone: _____ **( ) Mail:** _____

Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Divorced

Preferred Pharmacy #1: _____ **Preferred Pharmacy #2:** _____

Primary Insurance: _____ **Insured Name (as shown on insurance card):** _____

Contract #: _____ **Group #:** _____ **Effective Date:** _____

Secondary Insurance: _____ **Insured Name (as shown on insurance card):** _____

Contract #: _____ **Group #:** _____ **Effective Date:** _____

Nearest Relative (not living with you): _____ **Phone:** _____

As per the Federal Register Volume.77, No.144 Healthcare Facilities are required to collect Race, Ethnicity, and Language in order to comply with meaningful use. **Updated 9/21/17**