Medina Family Medical Clinic

Patient Information Sheet ***Welcome to our Practice***

Please complete and sign, then attach a copy of insurance card(s) and photo ID (driver's license):

PATIENT INFORMATION (Please print)

First Name: ______________________ MI: ______ Last Name ______________________

Address: ____

City: ______________________ State: ______________ Zip: ______________

Home Phone: (   ) ______________________ Marital Status: Single Married Divorced Widowed Separated

Date of Birth ______________ Age ______ Sex: ____ Social Security Number: ______________

Employer: ______________________ Work Phone: (   ) ______________

Employer's Address: ____

City: ______________________ State: __________ Zip: ______________

Student Status: Full-Time Part-Time Mother's Maiden Name: ______________

Preferred Pharmacy: ______________________ City __________ State ______________

Email Address: ____

Emergency Contact Info:

Name ______________________ Relationship: ______________

Phone Number (   ) ______________________ Work Phone: (   ) ______________

RESPONSIBLE PARTY INFORMATION

If you are the responsible party, mark "SELF" and move to the next page.

Patient's relationship to the responsible party: Self Spouse Child Other

Subscriber Information:

First Name: ______________________ MI: ______ Last Name ______________________

Address: ____

City: ______________________ State: ______________ Zip: ______________

Home Phone: (   ) ______________________ Marital Status: Single Married Divorced Widowed Separated

Date of Birth ______________ Age ______ Sex: ____ Social Security Number: ______________

Employer: ______________________ Work Phone: (   ) ______________

Employer's Address: ____

City: ______________________ State: __________ Zip: ______________

Signature: ______________________ ***Date:*** ______________