InteCare Medical Clinic
InteCareMedicalClinic.com

PATIENT INFORMATION SHEET

Date: _____

Patient's Legal Name _____ Last, First, MI

Birth Date: ____/____/____/ Age: ____
Address_____ Street, City, State
Zip ____Single ____Married ____ Widowed ____Male ____Female

Social Security Number _____/_____/_____

Home No. ( ) _____ Cell No. ( ) _____

Spouse's Name _____

Race: (circle one) Am. Indian, Asian, Native Hawaiian, Black or African Am., White or Caucasian, Hispanic, Other_____ Refuse to Report

Language: (circle one) English, Spanish, Indian (includes Hindu), Russian, Other_____

Ethnicity: (circle one) Hispanic, Non-Hispanic, Refuse to Report

Email Address _____

Please provide us with the name and phone number of one person (not living with you) to contact in case of an emergency: Emergency
contact_____Relationship_____

Phone ( )_____

Primary Care Physician _____

Who referred you to us? _____

Is your insurance in your name or another family member? _____Self OR
_____ (Name of Subscriber)

Primary Insurance Co: _____

ID Number: _____