Interfaith Community Clinic

PATIENT INFORMATION

NAME: _____
Last First Middle
Parent/Guardian: _____

ADDRESS: _____ _____ _____ _____ _____ _____
Street Apt. # City State Zip Code County

PHONE NUMBER: _____ _____ _____
Home Cell Work

DATE OF BIRTH: _____ **GENDER:** Male Female
Month/day/year

SOCIAL SECURITY No: _____

MARITAL STATUS:

Single		Divorced	
Married		Widowed	
Separated			

EMPLOYER: _____

EMPLOYMENT STATUS: Full Time Part Time
Not Employed Self Employed

EMAIL ADDRESS: _____

DO YOU HAVE MEDICAL INSURANCE, Medicare, Medicaid or Hospital District Coverage? YES NO

If yes, name of Insurer: _____

ADDITIONAL INFORMATION:

RACE:

African American/Black	
Asian	
Native American/American Indian	
Pacific Islander/Native Hawaiian	
White	

ETHNICITY:
Hispanic/Latino: YES NO

PRIMARY LANGUAGE: _____

NUMBER IN HOUSEHOLD: _____

HEAD OF THE HOUSEHOLD IS A FEMALE: YES NO

GROSS MONTHLY INCOME (For entire household)

WAGES: $_____

OTHER SUPPORT (Ex: WIC, Child Support, Social Security, Disability, Workmen's Comp):
$_____

SOURCE: _____

_____
Patient/Guardian Date