CLOVIS FAMILY HEALTHCARE

Section 1: Patient Demographics

Last Name: _____ First Name: _____ Middle: _____ Gender: _____

Social Security Number: _____ Date of Birth: _____ Marital Status: _____ Race: _____

Street Address: _____ City: _____ State: _____ Zip: _____

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

Preferred Reminder Method: (Circle One) Home Phone Cell Phone Mail Patient Portal

Emergency Contact: _____ Relationship: _____ Phone: _____

Section 2: Insurance Information

Insurance Company Name: _____

***IF** the patient is NOT the insured on the above listed plan, complete the following:

Policy Holder's Last Name: _____ Policy Holder's First Name: _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

Relationship to Patient: _____ Employer: _____ Phone (Home): _____ Phone (Work): _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____