CEDAR HILL PRIMARY CARE
New Information Packet

PATIENT INFORMATION

Prefix Mr. Ms. Mrs. Dr.	Last	First	Middle	Suffix ,I ,II ,III ,Jr ,Sr ,IV
Name you prefer to go by:	Birth/Maiden Name	Gender Female/Male	SSN	Marital Status Single Married Divorced Separated Widowed
Date of Birth / /	Race: Declined, Amer- Indian, Asian, African Amer, Caucasian, Hispanic, Other	Ethnic Group: Declined, American, Hispanic, African American, Asian, Other:		Language: English, Other:
Address Line 1:				
Address Line 2:				
Zip	City	State	Country	
Home Phone:	Cell Phone:	Work Phone:	Ext.	
Email:				
Preferred Contact Method:	□ Home Phone	□ Cell Phone	□ Work Phone	
Preferred Reminder Method:	□ Home Phone	□ Cell Phone	□ Work Phone	
Employer Name and Address:		Occupation:		
Driver's License #	Date of Expiration	State		

RESPONSIBLE PARTY INFORMATION

Name of Person Responsible Financially: Note if you are over the age of 18yrs you are responsible for yourself			
Last	First	MI:	
Patient's Relationship to the person that is Financially Responsible:	Self	Child	Spouse Other

Date of Birth / /	Race: Declined, Amer- Indian, Asian, African Amer, Caucasian, Hispanic, Other	Ethnic Group: Declined, American, Hispanic, African American, Asian, Other:	Language: English, Other:
Address Line 1:			
Address Line 2:			
Zip	City	State	Country
Home Phone:	Cell Phone:	Work Phone:	Ext.
Email:			
Employer Name and Address:		Occupation:	

EMERGENCY CONTACT INFORMATION

Person to Notify In Case of an Emergency:		
Last	First	MI:
Relationship to Patient:		
Home:	Cell:	Work:

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Continuation: **PATIENT INFORMATION SHEET**

Are you an Organ Donor: □ Yes □ No	Do you have a Living Will? □ Yes □ No □ Unknown
	Do you have an Advanced Directive? □ Yes □ No □ Unknown
Would you like to receive additional information about Advanced Directives? □ Yes □ No	
What is your most Commonly Used Pharmacy:	

(PRIMARY) INSURANCE INFORMATION

Name of Primary Insurance Company:			
Member ID Number:		Group Number:	
Name of the Primary Policy Holder: Last	First	MI:	Date of Birth of Policy Holder: / /
Patient's Relationship to the Primary Policy Holder: Self Child Spouse Other:			
Address Line 1:			
Address Line 2:			
Zip	City	State	Country

(SECONDARY) INSURANCE INFORMATION

Name of Secondary Insurance Company:			
Member ID Number:		Group Number:	
Name of the Primary Policy Holder: Last	First	MI:	Date of Birth of Policy Holder: / /
Patient's Relationship to the Secondary Policy Holder: Self Child Spouse Other:			
Address Line 1:			
Address Line 2:			
Zip	City	State	Country

(THIRD) INSURANCE INFORMATION

Name of Primary Insurance Company:		
Member ID Number:	Group Number:	
Name of the Third Policy Holder: Last	First	MI:
Patient's Relationship to the Third Policy Holder: Self Child Spouse Other:		

X _____

Signature **Date**