Family Medical Clinic
Telehealth Patient Information Form

Patient Information

SSN_______ -- _______ -- _________ Birthdate:___________________ Age:_____ Gender: M F

Last Name: _______________________ First Name: ___________________ Middle Initial: ______

Address: _____________________________________ City: __________ State/Zip: _______________

Home Phone # (______) ______ -- ___________ Cell Phone # (______) ______ -- ___________

Email address: _____________________________ May we contact you by email? Y N

Former Last Name: _________________________ Maiden Name: _______________________

Race (circle one): 1-American Indian/Alaskan Native 2-Asian 3-African American 4-White
5-Other __________________

Ethnicity (circle one) 1-Hispanic 2-Non-Hispanic Preferred Language: ____________________

Marital Status (circle one) S-Single M-Married D-Divorced W-Widow X-Legally Separated

Smoking Status: (circle one) *Required for every patient over 13*
Smoker--every day Smoker--some days Former Smoker Never

Military Status: (circle one) Y=Active Military N=Not Active Military

Employer (circle one): 005-Unemployed 001-Retired 111-Disabled 002-Student 004-Child

Employer Name:_______________________________ Employer Address: ______________________

City: _____________________ State/Zip: ____________________ Phone # : (______) ______ - ______

Guarantor Information (Parent or Legal Guardian)

SSN_______ -- _______ -- _______ Birthdate:___________________ Gender: Male Female

Last Name: _______________________ First Name: ___________________ Middle Initial: ______

Address: _____________________________________ City: __________ State/Zip: _______________

Home Phone # (______) ______ -- ___________ Cell Phone # (______) ______ -- ___________

Email address: _____________________________ May we contact you by email? Y N

Race (circle one): 1-American Indian/Alaskan Native 2-Asian 3-African American 4-White
5-Other __________________

Ethnicity (circle one) 1-Hispanic 2-Non-Hispanic Preferred Language: ____________________

Marital Status (circle one) S-Single M-Married D-Divorced W-Widow X-Legally Separated

Military Status: (circle one) Y=Active Military N=Not Active Military

Employer (circle one): 005-Unemployed 001-Retired 111-Disabled
039-Self Employed 004-Child *1-Full Time* *2-Part Time*

Employer Name:_______________________________ Employer Address: ______________________

City: _____________________ State/Zip: ____________________ Phone # : (______) ______ - ______

Emergency Contact (who can be reached when parent/guardian can not)

Print Name: _______________________________ Phone # : (______) ______ - ______

Address: ____________________________________ Relationship: __________________________

Parent Information

Mother Name: ____________________________ DOB: ____________ Phone # : ____________

Address: _________________________________ City: ____________ State/Zip: ____________

Father Name: ____________________________ DOB: ____________ Phone # : ____________

Address: _________________________________ City: ____________ State/Zip: ____________