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: _____