Family Health & Wellness Center, P.C.

Comprehensive Health Care for Men, Women and Children

General Patient Information

Today's Date _____

Legal Name _____ DOB _____

If married, maiden name _____

Sex: Male / Female (circle one) Age _____ SSN _____

Marital Status (circle one): Single Married Widowed Divorced

Race _____ Ethnicity _____

Primary Language _____

Email _____

Address _____ Apt #_____

City _____ State _____ Zip Code_____

Home Phone _____ Work Phone _____

Cell Phone _____ Employer_____

May we call or leave a message on your cell? ❑ **Yes** ❑ **No** May we call or leave a message at work? ❑ **Yes** ❑ **No**

If student, what school? _____

If patient is a minor, Parent/Legal Guardian_____ DOB_____

Preferred Pharmacy

Pharmacy Name _____

Pharmacy Address _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____

Insured _____ Insured _____

ID Number _____ ID Number _____

Group Number _____ Group Number _____

Primary Insured Information

Name _____ Relationship to patient _____

SSN _____ DOB _____

Address _____ Employer_____

Emergency Contacts

Contact #1 _____ Relationship _____ Phone _____

Contact #2 _____ Relationship _____ Phone _____