Patient Information

CFM CENTER FOR FAMILY MEDICINE

Today's date

Date of Birth	Social Security Number	Phone Number
First Name	Last Name	MI
Home Address		Apt or Unit Number
City	State	Zip Code

Sex At Birth ☐ Female ☐ Male	Gender ☐ Male ☐ Female ☐ Non-Binary	Pronouns	Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Email Address			How would you like to be contacted? ☐ Phone Call ☐ Email ☐ Text
Preferred Language	Do you require an interpreter? ☐ Yes ☐ No		Would you like to sign up for the Healow Patient Portal App? ☐ Yes ☐ No
Race ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Black/African American ☐ Mexican/Mexican American ☐ White			Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Employer Name ☐ Prefer not to answer			Employer Phone Number
Pharmacy Name & Location			Would you like to be contacted about financial assistance? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION (*AT LEAST ONE IS REQUIRED)

Please provide at least one emergency contact person below. There may also be times when you would like to give another person permission to discuss your treatment/care at Center for Family Medicine. I give my authorization to share information verbally regarding my treatment/care at Center for Family Medicine or contact in the event of an emergency, with the following:

Name	Relationship	Phone #	Do you give permission to discuss treatment with emergency contact? ☐ Yes ☐ No
Name	Relationship	Phone #	Do you give permission to discuss treatment with emergency contact? ☐ Yes ☐ No

SIGNATURE

Please sign here	Relationship to Patient (if minor)*

*IF PATIENT IS A MINOR

Mother	Date of Birth	Phone Number
Father	Date of Birth	Phone Number