the Family Doctors
West Jefferson Medical Center

Patient Information

Patient Name

Sex: M F Date of Birth Social Security #

Preferred Language

Race: Caucasian African American Asian Hispanic or Spanish Other

Address City State Zip

Home Phone Cell Phone E-mail

Employer Work Phone

Please check one: Married Single Partner Divorced Widowed Separated

PARENT (if minor) INFORMATION

Name Date of Birth

Social Security E-mail

Address City State Zip

Employer Work Phone

INSURANCE POLICY HOLDER INFORMATION

Name Date of Birth

Social Security E-mail

Address City State Zip

Employer Work Phone

PERSON RESPONSIBLE FOR PAYMENT

Responsible Party Relationship to Patient

Date of Birth Social Security # Home Phone

Address City State Zip

REFERRAL

If you are a new patient, how did you hear about the clinic or physician?

- 01 Recommended by a Friend or Family Member
- 02 Referred by a Physician
- 03 Phone Directory / Yellow Pages
- 04 Insurance Plan Directory
- 05 Employer
- 06 Community or Company Health Fair
- 07 Newspaper or Magazine
- 08 Internet or Clinic Web Site
- 09 Drove by Clinic / Location of Clinic
- 10 Other Source: Please List
- 11 Treated by Physician in the Hospital
- 12 Return Patient/ Not Applicable