Tschetter & Hohm Clinic

Patient Information Form

Patient Information

Full Name ____

Address _________________________________ City _________________ State _____ Zip ____________

Home Phone _____________________ Work Phone __________________ Cell Phone ________________

Social Security Number _______________________ Date of Birth (Month)_____ (Day) _____ (Year) _____

Marital Status ___________________

Patient Portal: Yes or No (Circle one) If yes, email address ____________________________________

(Circle one or fill in the blank for all 4 questions)

Race: American Indian / Asian / Black / Mexican American Indian / Spanish American Indian / White

Ethnicity: Hispanic / Non-Hispanic

Sex: Male / Female

Language: English / Karen / Spanish / Other_______________

Patient's Employer __________________________________ Occupation ___________________________

Employer's Address ____

Spouse/Parent Information

Name _____________________________________ DOB__________________ SSN___________________

Address (if different from above)____

Spouse/Parent Employer_________________________________ Employer Phone #__________________

Person Responsible for Bill _______________________________ Phone # __________________________

(If other than patient, spouse or parent)

Insurance Information (Please provide insurance cards)

Primary Insurance Company ____

Secondary Insurance Company ____

Other 3rd Party Payer ____

Emergency Contact

Full Name ____ Relationship _______________________

Address _________________________________ City _________________ State _____ Zip ____________

Home Phone _____________________ Work Phone __________________ Cell Phone ________________

Patient/Guardian Signature _______________________________________ Date ____________________