



Fredericksburg Christian Health Center
 Providing Affordable Quality Health Care
 To the Fredericksburg Community

PATIENT NAME _____ Today's Date: ___/___/___
Last Name First Name Middle Ini.

Date of Birth: ___/___/___ Age: _____ Marital Status: Single Married Widowed
 Divorced Separated

Sex: Male Female Home Phone #: (____)____-____ Social Security #: ____-____-____
 Race: _____ Cell Phone #: (____)____-_____

Mailing Address: _____ City/County: _____ State: ____ Zip: _____

Physical Address: _____ City/County: _____ State: ____ Zip: _____

Employer: _____ Work Phone #: (____)____-____ Occupation: _____

Employer's Address: _____ Pager #: (____)____-_____

IF YOU HAVE INSURANCE, PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD.

Type of Insurance: _____ Policy Holder Name: _____

Relation to Patient: _____ Policy Holder SSN #: ____-____-____ Policy Holder DOB: ___/___/___

Patient's Spouse's Information

Wife/Husband's Name: _____ Cell Phone #: (____)____-____ SSN#: ____-____-____

Spouse's Employer Name: _____ Spouse's Work #: (____)____-_____

IF PATIENT IS UNDER THE AGE OF 18 OR LIVING WITH PARENTS please fill out the next 2 areas

Father's Name: _____ SSN #: ____-____-____ Date of Birth: ___/___/___

Mailing Address: _____ City/County: _____ State: ____ Zip: _____

Home #: (____)____-____ Father's Employer: _____ Father's Work #: (____)____-_____

Mother's Name: _____ SSN #: ____-____-____ Date of Birth: ___/___/___

Mailing Address: _____ City/County: _____ State: ____ Zip: _____

Home #: (____)____-____ Mother's Employer: _____ Mother's Work #: (____)____-_____

EMERGENCY CONTACT NAME AND NUMBER: _____

Drug Allergies: _____

Current Medications: _____

Pharmacy Name and Number that you use for medications: _____

If you have a secure e-mail address and would like us to notify you by e-mail for normal lab and x-ray results, please list your email address: _____

