

College Station Family Medicine Center  
Registration Form

PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Work Phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_ Cell Phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM / DD / YYYY)

Sex: \_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Transgender Marital Status:  Not Married  Married  Divorced

What is your Ethnicity: (You must choose one): \_\_\_\_ Hispanic or Latino \_\_\_\_ Not Hispanic or Latino

What is your Race: (You must choose the one category that best describes your race)

\_\_\_\_ American Indian/Alaska Native \_\_\_\_ Asian \_\_\_\_ Black or African American

\_\_\_\_ Native Hawaiian or Pacific Islander \_\_\_\_ White (to include Hispanic or Latino)

\_\_\_\_ American Indian/Alaska Native & White \_\_\_\_ Asian & White

\_\_\_\_ American Indian/Alaska Native & Black or African American \_\_\_\_ Black/African American & White

\_\_\_\_ Race Combination not included in above categories – Specify: \_\_\_\_\_

Primary Language Spoken: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Employment Phone #: \_\_\_\_\_

Employment Address: \_\_\_\_\_

Have you or any family member ever been to the Clinic? \_\_\_\_ Yes \_\_\_\_ No Name of family member: \_\_\_\_\_

Family Member Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM / DD / YYYY)

Emergency Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Cell Phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

NAME OF RESPONSIBLE PARTY IF DIFFERENT THAN THE PATIENT LISTED ABOVE

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM / DD / YYYY) Relation to Patient: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Employment Phone #: \_\_\_\_\_

Employment Address: \_\_\_\_\_

College Station Family Medicine Center needs all patients to give us information on their income and family size to comply with the requirements of the Federal and State Grants that supports the clinic. Patients that desire reduced fees will be asked to provide additional information.

Estimated Annual Income: \_\_\_\_\_ Family Size: \_\_\_\_\_ Decline to Disclose Income

PAYMENT SOURCE\*: \_\_\_\_ Private Pay \_\_\_\_ Medicaid \_\_\_\_ Medicare \_\_\_\_ Medicare with Supplement Insurance

\_\_\_\_ CHIP \_\_\_\_ Commercial Insurance, Name of Insurance Company: \_\_\_\_\_

\_\_\_\_ Other \_\_\_\_\_

\*NOTE- PLEASE BE READY TO SHOW PROOF OF MEDICAID, MEDICARE, INSURANCE, CHIP, ETC.

\*\* THANK YOU \*\*