Patient Information Form

★ ZENGERLE ★
Medical Clinic

Name:_____ **DOB:**_____ **Age:** _____

Social Security #:_____ **Gender: Male** ___ **Female** _____

Home phone #: _____ **Cell#**_____ **Work #**_____

Physical address: _____ **City:** _____

Email address : _____ **State:** _____ **ZIP Code:**_____

Race/Ethnicity: _____ **Language (circle):** English Spanish **Other (List):**_____

Employment status:(circle one) Full time Part time Retired Unemployed

Employer:_____

Current/Previous primary care physician:_____

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Spouse name:_____ **Spouse phone#**_____
Spouse DOB:_____
Spouse employment status (circle): Full time Part time Retired Unemployed
Spouse employer:_____
****

IF PATIENT IS A MINOR COMPLETE THIS SECTION

Father:_____ **DOB:**_____
Father's phone number:_____ **SocSec#:**_____
Mother:_____ **DOB:**_____
Mother's phone number:_____ **SocSec#:**_____
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Emergency Contacts

1. _____**DOB:**_____**Relationship:**_____**Phone#**_____
Email address : _____
2. _____**DOB:**_____**Relationship:**_____**Phone#**_____
Email address : _____
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If you currently have insurance, please provide a card so that we may copy it if needed for referrals and other testing.