LAREDO MINOR EMERGENCY CLINIC

COMPLETE FAMILY HEALTH CARE

Melchor P. Cardenas, MD

PATIENT INFORMATION FORM

Name: _____ DOB: _____

Address: _____ Male: ( ) Female: ( )

City: _____ State: _____ ZIP Code: _____ SSN: _____

Phone: (_____) _____ Cell: (_____) _____

Marital Status: ( ) Single ( ) Married ( ) Divorce ( ) Widow ( ) Separated

Race: ( ) African American ( ) White ( ) Asian ( ) Native American ( ) Ethiopian
( ) Other _____

Ethnicity: ( ) Hispanic/Latino ( ) White ( ) Native American ( ) Other: _____

Language: ( ) English ( ) Spanish ( ) Other _____

Dominant Hand: ( ) Right ( ) Left

Gender Identity: ( ) Male ( ) Female ( ) Other
( ) Transgender Female/ Male to Female ( ) Transgender Male/Female to Male

Sexual Orientation: ( ) Straight ( ) Bisexual ( ) Gay/Lesbian ( ) Choose not to disclose

E-Mail: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ Phone: (_____) _____

INSURANCE INFORMATION

Medicaid ( ) Medicare ( ) Self Pay ( ) W/C ( ) Private Insurance ( )

REFERRED BY: _____

LAST NAME _____ FIRST NAME _____

DOB (M/D/Y): _____/_____/_____

Employment Information

Employer Name: _____

Address: _____ Phone#_____

Employment Status: ( ) Employed ( ) Retired ( ) Full Time Student ( ) Part Time Student

( ) Unemployed

Occupation: _____Department:_____

Employed From _____ to _____

Allergy Information

Are you allergic to any medication? ☐ **YES** ☐ **NO**

IF YES, SPECIFY:

_____

Do you believe you have allergies? ☐ **YES** ☐ **NO**

Do you take any over the counter allergy medicine (EXP. CLARATIN)? ☐ **YES** ☐ **NO**

FINANCIAL RESPONSIBLITITY

I acknowledge that I will be responsible for any amount that is not covered by my insurance.

AUTHORIZATION

I authorize the release of any Medical Information necessary to process an insurance claim and request payment of benefits either to myself or to the party who accepts assignment. I also authorize the Laredo Minor Emergency Clinic to complete this form on my behalf.

_____ _____

Patient's Signature Date Date