Greystone Medical Clinic
PATIENT INFORMATION FORM

Name: _____Birth Date: _____Sex: ____M____F

Address: _____City/Sate:_____Zip_____

SS#:_____-_____-_____Driver License#:_____DL State:_____

Home Phone: (_____)_____Cell Phone: (_____)_____

Employer Name:_____ Employer Phone:(_____)_____

RACE (please circle one):
Caucasian
Black
Asian
American Indian
Hispanic
Pacific Islander
Other

ETHNICITY (please circle one):
Hispanic or Latino
Not Hispanic or Latino

LANGUAGE (please circle one):
English
Spanish
French
Other

IF PATIENT IS A MINOR:

Mother's Name: _____Birth Date: _____

Address: _____City/Sate:_____Zip_____

Home Phone: (_____)_____Cell Phone: (_____)_____

SS#:_____-_____-_____Driver License#:_____DL State:_____

Employer Name_____ Employer Phone: (_____)_____

Father's Name: _____Birth Date: _____

Address: _____City/Sate:_____Zip_____

Home Phone: (_____)_____Cell Phone: (_____)_____

SS#:_____-_____-_____Driver License#:_____DL State:_____

Employer Name_____ Employer Phone: (_____)_____

EMERGENCY CONTACT:

Name:_____Realtionship_____

Home Phone: (_____)_____Cell Phone: (_____)_____

- ***I authorize release any information concerning my (or my child's) healthcare, advice, and treatment for the purpose of evaluation and submitting claims for insurance benefits. Understand that I am responsible for any amount not covered by insurance. I will notify Greystone Medical Clinic of any changes in the above information, in a timely manner.***

Print Name (parent if patient is a minor): _____

Signature (parent if patient is a minor): _____Date_____