Hamby & Hamby
FAMILY MEDICAL CLINIC & MED SPA

PATIENT INFORMATION

Please complete all information

Last Name _____ First Name _____ MI _____

Previous Name (s) _____

Address _____ Apt #_____

City _____ State _____ Zip _____

Please circle brief (only our name and phone number) or extended (our name, phone and any pertinent information) so we know which message to leave. If neither is circled we will leave a brief message.

Home Phone _____ brief extended Cell Phone _____ brief extended

Work Phone _____ Ext _____ brief extended

Date of Birth _____ Sex _____ Email _____

Marital Status (circle one) Married Single Divorced Widowed Legally Separated Other _____

Social Security # _____

Employment Status (circle one) Full time Part time Not employed

Employer Name _____

Address _____ City _____ State _____ Zip _____

Student Status (circle one) Full time Part time Not a student

Name of School _____

Emergency Contact

Name _____ Relationship_____

Address _____ City _____ State _____ Zip _____

Phone _____

Responsible Party-who the bill will be sent to-this MUST be the same person who signs responsible party form

Name _____ Relationship_____

Address _____ City _____ State _____ Zip _____

Phone _____

Where do you live? (circle one)

Private home
Skilled nursing home
Nursing home
Residential Home (Legacy Hts.)

What is your living status? (circle one)

Single family home
Homeless
Migrant
Seasonal
Street
Transitional
Doubling up (living with someone else due to financial hardship)
Other

Race _____ Hispanic _____ Non-Hispanic _____

Birth order _____ for example were you born 1st, 2nd, 3rd, etc. Language _____

If patient is under 18 do they fit one of the criteria for free immunizations? (circle one)

1. Medicaid/Medicare
2. Uninsured
3. Under Insured (insurance does not cover immunizations)
4. ARKids First
5. American Indian or Alaskan-proof not needed
6. None of the above

Please list 3 personal contacts we may use to reach you that do not live with you

Name _____ Relationship_____

Address _____ City _____ State _____ Zip _____

Phone _____

Name _____ Relationship_____

Address _____ City _____ State _____ Zip _____

Phone _____

Name _____ Relationship_____

Address _____ City _____ State _____ Zip _____

Phone _____

Pharmacy Name _____ City _____

If Wal-Mart or Walgreens please list street name _____

Mail Order Pharmacy (if requested)

Name _____
Address _____
Phone _____
Fax _____

If this is because of a workers comp accident, please list case worker information

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____

If this is a child in DHS custody, please list case worker information

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____