MRN:_____

TEMPLE Community Clinic
HEALTH, EDUCATION, AND WELLNESS

Last_____ **First** _____ **MI** _____ **Suffix** _____

DOB_____ **Gender** (Circle) M F

Marital Status (Circle) Single Married Widowed Divorced Other

SSN: _____

Home Address _____ **City** _____ **State** _____ **Zip**_____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email Address _____ **TX Photo ID#** _____ **County** _____

Race (Circle) Black Asian White Native American

Ethnicity (Circle) Hispanic Non Hispanic Unknown

Primary Language Read _____ **Primary Language Spoken** _____

Employer Name _____

Proof of Income (Circle) Tax Return Paycheck Stub Employment Letter Unemployment Disability Bank Statement Social Security Support Letter

Employment Status (Circle) Employed FT Employed PT Disabled Retired Unemployed Other

Household Size ____ **Household Income (Annual)** _____ **Patient Income** _____ (Circle) Hourly BiMonthly Monthly Annual

Education (Circle) Grades K-12 High School Diploma GED 2 yrs or Less College 2 yr College Degree 2-4 yrs College No Degree 4 yr College Degree Advanced Degree Unknown

Updated 03/30/2020

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Patient Contact Information

Patient Name _____ DOB_____

I realize correspondence and contact information will be used only to contact me. Information regarding my medical condition or diagnosis will not be discussed with anyone other than the persons listed below.

Please list the family members or other persons, if any, who we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Please list the family member or other persons, if any, who we may inform about general medical conditions and you diagnosis:

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____