FLOYD SM

Patient Information

Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

SS#: _____ **DOB:** _____

(Please circle)

Patient's Preferred Language: English Spanish Other: _____

Ethnicity: Non-Hispanic Hispanic

Race: African American Asian Caucasian Hispanic Other: _____

Medical Question:

Has the student had a wellness visit in the past 2 years? Y or N

If, Yes (Physician) _____

Is the student currently on medication? Y or N

Does the student have a chronic illness that is being managed by a physician? Y or N

Insurance Information

Please send a copy of the insurance card or cards in with this form. Copy of driver's ID

Insurance Company: _____

Name of Insured: _____ **Insured's date of birth:** _____

Relationship to patient: _____

Employer: _____ **Phone:** _____

Billing Information – (who is responsible)

Name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Relationship to Patient: _____

Employer: _____