

# CITY CARE CLINIC REGISTRATION FORM

**This information will remain confidential. Financial data must be verified with an income statement such as a tax form every 6 months for qualification.**  
(Please print)

Clinic ID Number:

Today's date:			Inception date:			
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	MI:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.:		Home phone #: Cell Phone #:		
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.:			(    )	
Monthly income:	Monthly expenses:	Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family		<input type="checkbox"/> Friend	<input type="checkbox"/> Church	<input type="checkbox"/> Other	<input type="checkbox"/> Dr.	
Other family members seen here:						
Children:		Ages:	Other Dependants:			
<b>IN CASE OF EMERGENCY</b>						
Name of local friend or relative:		Relationship to patient:	Home phone no.:	Work phone no.:		
			(    )	(    )		
<p>The above information is true to the best of my knowledge. I attest that I have read and signed the contract for receiving health care from the City Care Clinic. I authorize the City Care Clinic to release any information required to other physicians or hospitals for the sole purpose of continuity of my health care.</p>						
<i>Patient/Guardian signature:</i>				<i>Date:</i>		

You will receive an identification card after you have been qualified for medical services. Please bring this to your office visit and display it to the receptionist at the time of your appointment.

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Clinic use only

Comments:

Accepted:    Y    N

Renewal date: