LUCAS COUNTY HEALTH CENTER

An Affiliate of UnityPoint Health

CHARITON CLINIC

# Patient Information Sheet

## Patient Information

Last Name: _____ First Name: _____

Preferred or Nickname: _____ Maiden Name: _____

Date of Birth: _____ Gender: _____ Social Security #: _____

Race: _____ Ethnicity:_____ Marital Status (circle): M S D W

Primary Language used, if not English: _____

Address: _____

City, State, Zip: _____ County: _____

Home Phone: (_____) _____-_____ Alternate Phone: (_____) _____-_____

Primary Phone (circle): Home Alternate

Email Address: _____

Preferred Provider: _____ Preferred Pharmacy: _____

Employer: _____ Occupation: _____

Employer Address: _____

City, State, Zip: _____ Hire Date: _____

Status (circle): Full-time Part-time Phone: (_____) _____-_____ Extension: _____

## Responsibility Billing Party (if different than above)

Name: _____ Phone: (_____) _____-_____

Address: _____

City, State, Zip: _____

Social Security #: _____ Date of Birth: _____

Relationship to Patient (circle one): Patient Spouse Mother Father Guardian

**Signature:** _____ **Date:** _____

**A copy of your driver's license and insurance card is required at the time of registration.**