Corridor Primary Care Internal Medicine
Patient Information

Date ______________ How did you hear of us? ______________

Patient Name ______________________________ Gender: M F
Date of Birth ________________ SS # ______________________
Local Address ______________________________________
City ______________________ State ______ Zip __________
Phone: Home __________________ Work ____________________
Cell/Alternate ______________________________________
Permanent Address (if different):

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City ______________________ State ______ Zip __________

Marital Status: Single Married Divorced Widowed Partnered
Spouse/Partner Name ______________________________
Spouse/Partner Contact # ___________________________
Parent/Guardian Name(s) ___________________________
Parent/Guardian Contact # __________________________

Emergency Contact (other than spouse/parent)
Name _________________________ Relation ____________
Phone _______________ Address _______________________

Race: African-American White/Hispanic Asian
Primary Ethnic group: Hispanic/Latino OR Non-Hispanic/Latino
Preferred Language(s) ___________

Is a relative a patient of this clinic? If yes, please write name:

____

I authorize CPC to share medical information with the following people:
Name __________________ Contact # ________ Relation __________
Name __________________ Contact # ________ Relation __________
Name __________________ Contact # ________ Relation __________

Completed by (Sign:) ____________________________________

Revised: 9/1/11