HUNEYCUTT FAMILY MEDICINE

Patient Name_____Today's Date_____

Parent or Guardian Name_____

Street Address_____Birthdate_____

City_____State_____Zip code_____

Home Phone Number ( )_____Cell Phone Number( )_____

Marital Status S____M____D____W____Other____ Soc. Sec. #_____

Employer_____Work Phone Number ( )_____

E-Mail Address_____

Reason for visit_____Method of payment_____

Pharmacy you wish to use if known_____ Phone_____

How did you learn about of clinic? (Please check one)
Referral from_____
Newspaper Ad____
Web Page____
Sign in front of clinic:____
Other_____

I have been offered a Notice of Privacy Practices brochure: I accept_____ I decline_____
*Patient signature*_____

NOTICE: PLEASE TAKE THIS FORM TO THE FRONT DESK WITH YOUR DRIVERS LICENSE. ALSO BRING YOUR INSURANCE CARD IF WE ARE TO FILE ON YOUR INSURANCE.

We would like to thank you for giving us the opportunity to meet you and help with your healthcare needs.

For office use: Weight_____ Height_____