# Client Information
# Family Center by the Falls

**Patient Name:**_____
**Mother Name:**_____ **Cell:**_____
**Father Name:** _____ **Cell:**_____
**Patient Home Address:**_____
**City, State, Zip:**_____
**Email Address:**_____
**Can we use this email to notify you of upcoming appointments? Yes No**
**Patient Social Security #:**_____ **Patient Date of Birth:**_____
**Patient Cellular Number:**_____
**Patient Home Phone Number:**_____
**Patient's School:**_____
**School Contact Person (optional):**_____**Phone Number:**_____

***Circle all that apply:***

**Preferred Way to Contact: phone email**
**Gender: Male Female**
**Race: White Black Asian American Indian Hispanic Other**
**Parent Marital Status: Single Married Divorced Widowed**
**Patient Employment Status: Full-time Part-time Student Unemployed**
**Student Status: Full-time Part-time**

**Emergency Contact:**
**Name:**_____**.** **Phone:**_____ **Relationship:**_____

**Primary Care Physician (PCP):**_____
**PCP Address:**_____

**Who referred you to our practice?**_____

**Insurance Name:**_____
**Name of person insured:** _____
**Soc. Sec. # of insured**_____ **Insured date of birth:**_____
**Insurance company address on card:**_____
**Policy Type:**_____
**Member Number:** _____ **Group Number:**_____
**Group Name:**_____