

Dickson County Schools' Family Clinic

Date: _____

Medication Allergies: _____

Name: _____

Last

First

Middle Initial

Social Security #: _____

Date of Birth: ____/____/____

Sex: Male Female Marital Status: _____ Name of spouse: _____

Home Address/Po Box: _____ APT # _____

City

State

Zip Code

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email address: _____

Please circle your preferred method of contact: Home Cell Email

May we leave a message at the above listed number: Yes No

Employer and Department: _____

Are you insured through the employer listed above: Yes No

Relationship to Employee: Self Child Other

Name of Emergency Contact (Not living with you)

_____ Phone #: _____ Relationship: _____

List the names of persons we may speak to concerning your health. Note that any person on this list may receive information concerning your care provided at this clinic. If you do not want your health related information to be disclosed to someone please do not list them.

To the best of my knowledge the information listed above is true and accurate.

X _____

Patient Signature or Guardian of minor patient