Four Oaks Medical Clinic

109 Shult Drive
Columbus, TX 78934

If this is a work related injury, please notify the receptionist prior to completing this form.

Patient Information ***Please Print***

Today's Date ______________________________

Name ____
First Middle Last Suffix Maiden

Mailing Address ____

City ____________________________ State __________________ Zip__________

Physical Address ____

City ____________________________ State___________________ Zip__________

Gender □ Male □ Female Social Security # _________________________

Marital Status □ Single □ Married □Divorced □Separated □Widowed Date of Birth___________________

Race □ Decline □ American Indian □ Black □ Pacific Islander □ Asian □ White/Hispanic □ Other

Ethnicity □ Decline □ Hispanic □ Not Hispanic

Primary Language ______________________________ Primary Physician ________________________

Please Put at least one phone number

Home _________________________ Email _________________________________

Work _________________________ Preferred Phone □ Home □ Cell □ Work

Cell _________________________ Preferred Contact Method □ Phone □ Email □ Mail

Emergency Contact: _____________________ Relation: ____________ Phone #: ____________________________

Pharmacy: _________________________________ Phone #: _____________________________________

Guarantor Information

Responsible Party ____
First Middle Last Suffix Maiden

Relationship □ Self □ Spouse □ Parent □ Guardian □________________________ Gender □ Male □ Female

Date of Birth _________________________________ Social Security # _______________________

Address ____

City _________________________________ State ___________________ Zip _______________

Home Phone _________________________________ Cell phone __________________________________

Please provide the receptionist with your insurance card(s)