# COAL CREEK FAMILY MEDICINE
## NEW PATIENT QUESTIONNAIRE

Patient's First & Last Name: _____DOB: _____ SSN*: _____

If patient is a minor, name of parent or Legal Guardian: _____

Address: _____City & State: _____Zip: _____

E-Mail: _____ How were you referred to us? _____

Patient Home Telephone: _____ May we leave a detailed message? Yes No

Patient Cellular Telephone: _____ May we leave a detailed message? Yes No

Patient Work Telephone: _____ May we leave a detailed message? Yes No

Please select the following **Race(s)**:

- ○ White/Caucasian
- ○ Asian
- ○ Black or African American
- ○ Native American Indian
- ○ Native American or Alaskan Native
- ○ Native Hawaiian
- ○ Other Pacific Islander
- ○ Decline to Specify

Please select the following **Ethnicity:**

- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Other
- ○ Decline to Specify

Who do you designate as your **Primary Care Physician** (this is the physician you will see in our practice)?

_____

What insurance do you have: _____Member ID/Policy #: _____

Group #: _____ Who is the policyholder?: _____

Please List an Emergency Contact (only one) :

_____ _____
Name Relationship

_____ _____
Phone Number Alternate Phone Number

_____ _____
**Patient Signature/Parent/Guardian** **Today's Date**