Centro De Salud Familiar La Fe Inc

1314 E Yandell
El Paso, TX 79902
(915) 534-7979

To be completed by member!

PATIENT INFORMATION

NAME (Last, First Middle)			MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	

NAME OF INSURED	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT $

CITY, STATE ZIP	PHONE	DEDUCTIBLE $	

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	

NAME OF INSURED	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT $

CITY, STATE ZIP	PHONE	DEDUCTIBLE $	

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____