The Prairie Clinic
Patient Information Form

Patient Information

Name:______________________ SS#___________________Date:___________

Address:____
Street City State Zip

School: ____

Phone:____________________ Work Phone:_____________________

Email____
If patient is a minor, provide email of parent

Personal and Family Information

Patient's Birthdate:_________________ Age:__________

□ Single □ Married □ Widow/Widower □ Divorced

If previously married, lists date(s) and duration:______________________________

If parents divorced, please describe custody arrangement ______________________
____

Current spouse's name:______________________________ DOB____________
Spouse's occupation:________________________________ Phone___________

Natural father's name:______________________________ DOB____________
Occupation:_______________________________________ Phone___________

Natural mother's name:______________________________ DOB____________
Occupation:_______________________________________ Phone___________

Stepfather's name:_________________________________ DOB____________
Occupation:_______________________________________ Phone___________

Stepmother's name:_________________________________ DOB____________
Occupation:_______________________________________ Phone___________