HIGHLAND CLINIC
A Tradition in Health Care.

MR# _____

Patient Name/Last:	Suffix:	First:	Middle:	SSN:
Residence Address:		City:	State:	Zip:
Mailing Address: (Check here if same as above) ☐				
Email Address:		Cell Phone Number:	Home Phone Number:	
Date of Birth/Month:	Day:	Year:	☐ Male ☐ Female	Race: Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Employer's Name:		Work Telephone Number:	Ext:	
Preferred Language: ☐English ☐ Spanish ☐ Other			Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Communication Needs: ☐Hearing ☐Speech ☐Other		Preferred Pharmacy:	Address:	
Who referred you to our office?		Telephone Number:		
Responsible Party: (check here if same as above) ☐				
Name/Last:	First:	Middle:	Responsible party's SSN:	Date of birth:
Mailing Address:		City:	State:	Zip:
Home Phone Number:		Relationship to Patient:		
Employer's Name:		Work Phone Number:	Ext:	

In Case of an Emergency, who may we notify?

Name #1:	Telephone Number:	Relationship to patient:
Name #2:	Telephone Number:	Relationship to patient:

Insurance Coverage Is your illness/injury due to an auto/work accident? Yes ☐ No ☐

Insurance #1 Name of insurance company:		
Policy Number	Group Number:	
Employer:	Subscriber:	Subscriber DOB:
Insurance # 2 Name of Insurance company:		
Policy Number	Group Number:	
Employer:	Subscriber:	Subscriber DOB:
Insurance # 3 Name of insurance company:		
Policy Number	Group Number:	
Employer:	Subscriber:	Subscriber DOB:

I declare that the above information is true and correct to the best of my knowledge. Date:_____ Signature:_____