NEW PATIENT INFORMATION

Clovis Community Medical Center

Identification Information

First Name: _____

Middle Initial: _____

Last Name: _____

SSN: _____

DOB: _____

Marital Status: _____

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Caucasian ☐ Hispanic/Latino
☐ African American
☐ Asian/Pacific Islander
☐ Native American ☐ Other

Preferred Language: _____

Worker's Comp Related: ☐ Yes ☐ No

Occupation: _____

Employer Name: _____

Employer Phone: _____

Care Providers

Referring MD: _____

Speciality: _____

Phone: (_____) _____-_____

Primary MD: _____

Speciality: _____

Phone: (_____)_____-_____

Advanced Directive: ☐ Yes ☐ No

Durable Power of Attorney: ☐ Yes ☐ No

Do Not Resuscitate: ☐ Yes ☐ No

Living Will: ☐ Yes ☐ No

Contact Information

Address 1: _____

Address 2: _____

City: _____

State: _____ Zip: _____

Phone: (_____)_____-_____

Secondary: (_____)_____-_____

Care Center: _____

Admission Information

How Heard: _____

New to Hospital: ☐ Yes ☐ No

Family/Emergency Contact Information

First Name: _____

Last Name: _____

Relationship: _____

Contact Phone: (_____)_____-_____

Caregiver Information

Capable of Self Care: ☐ Yes ☐ No

Caregiver: ☐ Yes ☐ No

First Name: _____

Last Name: _____

Caregiver Phone: (_____)_____-_____

Home Health Company: _____

Phone: (_____)_____-_____

Nurse's Name: _____