Family Care
Walk-in Clinic

400 US HWY 45 W
Three Way, TN 38343
(731) 784-7773 • (731) 784-0001 fax

176-C West University Parkway
Jackson, TN 38305
(731) 660-6915 • (731) 668-4557 fax

PATIENT INFORMATION (Please Print)

NAME _____ SOCIAL SECURITY # _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE (HOME/CELL) _____/_____ DATE OF BIRTH _____

STATUS: _____ SINGLE _____ MARRIED _____ DIVORCED SEX: _____ FEMALE _____ MALE

EMPLOYER _____ TELEPHONE _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

Email: _____ **May we email results to you? Please Circle Yes No**

CONTACT IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____

PHONE NUMBERS(HOME/CELL) _____/_____

IF THE PATIENT IS A MINOR CHILD

RESPONSIBLE PARTY _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBERS(HOME/CELL) _____/_____ DATE OF BIRTH _____

INSURANCE DATA AND POLICY HOLDER INFORMATION

PRIMARY INSURANCE _____ POLICY # _____ GROUP #_____

POLICY HOLDER _____SS#_____ DATE OF BIRTH OF POLICY HOLDER _____

ADDRESS OF PRIMARY HOLDER _____

CITY _____ STATE _____ ZIP _____

SECONDARY OR SUPPLEMENT POLICY _____POLICY #_____

POLICY HOLDER _____ DATE OF BIRTH OF POLICY HOLDER _____

ADDRESS OF PRIMARY HOLDER _____

CITY _____ STATE _____ ZIP _____

- **I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE PAYMENT FOR ANY PROFESSIONAL SERVICES I RECEIVE FROM FAMILY CARE WALK IN CLINIC. I HAVE READ THE ABOVE LISTED DATA AND HAVE RESPONDED TO ALL DATA REQUESTED THAT IS APPLICABLE TO M Y PERSONAL AND INSURANCE DATA. I CERTIFY THAT THE ABOVE INFORMATION THAT I HAVE PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHERMORE, I WILL ADVISE YOU OF ANY CHANGES THAT MAY OCCUR WITH REGARDS TO MY PERSONAL OR INSURANCE DATA.**

SIGNATURE _____ DATE _____

PARENT OR GUARDIAN (IF MINOR) _____ DATE_____