916 South 3rd Street
Mt. Vernon, WA 98273-4324
Voice: (360) 336-5658
Fax: (360) 336-5655

Demographics

Date: _____

Last Name: _____First Name: _____ MI:_____

Preferred Name (if applicable): _____ Maiden Name (if applicable): _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Preferred Pharmacy (please select one): _____City:_____

Race (check one): ____White ____American Indian/Alaska Native ____Asian
____Black/African American ___Nat Hawaiian/Pacific Is ____Other _____Declined

Ethnicity (check one): ____ Hispanic/Latino _____Not Hispanic or Latino _____Declined

Primary Language (check): ____English ____Other:_____ Marital Status: _____

Driver's License State/No: _____ Religion: _____

Mother's Name (minors only): _____ *DOB:* _____

Father's Name (minors only): _____*DOB:* _____

Child lives with: □ *both parents* □ *mother* □ *father* □ *other* _____

Who will be the guarantor for this account? _____*Date of Birth:*_____

*Address (if different from patient)*_____*Phone:*_____

Mailing Address_____

City: _____ State: _____ Zip code: _____

Street Address: _____ Apartment #: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email (required for patient portal): _____

Preferred Communications: ____Cell phone ____Home phone ____Work phone ____Mail ____Email ___
____Text

See Other Side

SKAGIT Family HEALTH CLINIC

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Employer: _____ Occupation: _____

Emergency Contact: _____ Contact's Phone #: _____

Primary care provider (PCP)? Dr._____ Phone #:_____

How did you hear about our clinic? _____

Primary Insurance Company: _____

ID Number: _____ Group/Policy Number: _____

Name of policy holder: _____ **If policy holder is the same, check here:** □

Policy holder's DOB: __ _____ Policy holder's SSN: _____

Relationship to policy holder: □ spouse □ child □ other _____

Secondary Insurance Company: _____

ID Number: _____ Group/Policy Number: _____

Name of policy holder: _____ DOB: _____ SSN: _____

Relationship to policy holder: □ spouse □ child □ other _____

See Other Side