FOSSIL CREEK FAMILY MEDICAL CENTER

PATIENT SIGN IN SHEET

Date: _____ **Parent/Guarantor:** _____

Patient Name: _____ **DOB:** _____

Current Address: **Same for Whole Family?** ☐ **YES** ☐ **NO**

_____

Street **Apt #** **City** **ZIP Code**

Current Phone:

(Home) _____

(Work) _____

(Cell) _____

E-Mail Address: _____

Insurance Carrier: _____

ID#: _____

☐ **I do not have insurance**

Pharmacy: _____

Name **Address**

Pharmacy Phone #: _____