

Columbus Medical Clinic
2122 Hwy 71 S, Ste 101
Columbus, TX 78934

If this is a work related injury, please notify the receptionist prior to completing this form.

Patient Information *Please Print*

Today's Date _____

Name _____
First Middle Last Suffix Maiden

Mailing Address _____

City _____ State _____ Zip _____

Physical Address _____

City _____ State _____ Zip _____

Gender Male Female Social Security # _____

Marital Status Single Married Divorced Separated Widowed Date of Birth _____

Race Decline American Indian Black Pacific Islander Asian White/Hispanic Other

Ethnicity Decline Hispanic Not Hispanic

Primary Language _____ Primary Physician _____

Please Put at least one phone number

Home _____ Email _____

Work _____ Preferred Phone Home Cell Work

Cell _____ Preferred Contact Method Phone Email Mail

Guarantor Information

Responsible Party _____
First Middle Last Suffix Maiden

Relationship Self Spouse Parent Guardian _____ Gender Male Female

Date of Birth _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell phone _____

If applicable, please provide the receptionist with your insurance card(s) to be scanned in the computer.