SAINT LOUIS MEDICAL CLINIC

SLMC Account #_____

Patient Demographic Information

PLEASE PRINT LEGIBLY

Patient Name / Information		
First	Middle	Last
Date of Birth	Gender ○ MALE / ○ FEMALE	Ethnicity ○ NON-HISPANIC / ○ HISPANIC
Race ○ AFRICAN AMERICAN / ○ AMERICAN INDIAN / ○ ASIAN / ○ CAUCASIAN / ○ OTHER RACE		

Contact Information		
Street Address		
City	State	Zip

Phone / E mail / Pharmacy (Place a ✓ by PRIMARY phone number)		
☎Home	☎Cell	☎Alternate
✉E-mail Address		
Preferred Pharmacy	Pharmacy Location/City	

Employment	
Employer	Work Phone

Emergency Contact		
Name	Relationship to Patient	Phone

Insurance	
PRIMARY Insurance	Effective Date
Policy Holder Name	Relationship to Patient
Group#	ID#

SECONDARY Insurance	Effective Date
Policy Holder Name	Relationship to Patient
Group#	ID#

Signature of Patient or Representative

Date