Waynesboro Family Medicine & Obstetrics Clinic

Patient Information

Please Print:

Name: _____
Last First Middle Initial

Mailing Address:

_____

_____

Email Address: _____

Home Phone: _____ Cell Phone: _____

SS# _____ Sex M F Marital Status: _____

Birthday: _____ Age: _____

Occupation: _____ Employer: _____

Responsible Party (if other than yourself or the patient is a minor):

Name _____ Phone number: _____

Relationship to patient: _____

Address (this is where the bill for the patient will be sent):

_____

_____

Other Information:

Emergency Notification Name: _____ Phone: _____

Relationship: _____

Allergies: _____

Previous Surgeries/ Illnesses (list dates and medical conditions):

_____

_____

Please list medications you are currently taking:

_____

_____

_____

If you want access to your electronic medical record through our Patient Portal please list your email here: _____