RED RIVER FAMILY PRACTICE, LLP

Michael E. Killian, MD Cynthia Brinson, MD J. Eric Lambeth, MD
Gary L. Werntz, MD Mary Bartz, MD Steven B. Hutto, MD

PATIENT INFORMATION FORM

_____ _____ _____ _____
Last Name First Name Middle Initial Preferred/Nickname

_____ Mr. Ms. Mrs _____ _____
Maiden Name Prefix (Circle) DOB Sex

Marital Status (Circle One): M S W D P Driver's License #: _____

Primary Language: _____ Preferred Communication: _____

Home Address: _____ Phone #: _____

Email: _____ Preferred Provider: _____

Emergency Contact: _____ Phone #: _____ Relation: _____

Employer: _____ Phone #: _____

Primary Insurance:

Name: _____ ID #: _____

Policy Holder: _____ Group #: _____

Policy Holder Relationship: _____

Secondary Insurance:

Name: _____ ID#: _____

Policy Holder: _____ Group #: _____

Policy Holder Relationship: _____

Electronic Prescription & Records Consent: Please Circle Yes No

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