Bolingbrook Christian Health Center
Serving One Another in Love Galations 5:13

New Patient Information

Date: _____

Name: _____ Middle: _____ Last Name: _____

Address: _____ Apartment No: _____ Building No: _____

City / State: _____ Zip Code: _____ Sex: Male ☐ Female ☐

Date of Birth: _____ _____ _____
Month Day Year

Social Security # _____ - _____ - _____

Evening Phone # _____

Daytime Phone # _____

Cell Phone # _____

Marital Status:

☐ Single
☐ Married
☐ Divorced
☐ Widowed

Emergency Contact: _____

Emergency Phone # _____

If patient is a child: _____
Name of Parents

Languages Spoken:

☐ English ☐ Hindi
☐ Spanish ☐ Philippine
☐ Arabic
☐ Chinese ☐ Other _____

Family Information:

Spouse's Name: _____

Family Size: _____

Yearly Income: _____

Health Insurance: ☐ Yes ☐ No

Medicare: ☐ Yes ☐ No

Medicaid: ☐ Yes ☐ No