



**TMH Medical Clinic**  
 (970) 826-2400 office (970) 826-2439 fax  
 785 Russell Street  
 Craig CO 81625

**Please fill out form completely      Adult Intake**

Patient Name: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M or F  
Last First MI

Mailing Address: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ SS#: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Secondary Phone #: \_\_\_\_\_ Nickname/Preferred Name: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M or F  
Last First MI

Primary Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

City/State: \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Card Holder's Name: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_ Phone # \_\_\_\_\_

Health Information can be left:

Primary #  Secondary #  Other # \_\_\_\_\_  E-mail \_\_\_\_\_

Preferred Pharmacy:  City Market  Safeway  Walmart  Walgreens  Other \_\_\_\_\_

UDS Reporting:

Language best served in:  English  Spanish  Greek  other \_\_\_\_\_

Housing status:  Not homeless  Doubling up  Transitional  Homeless

Agricultural status:  Migrant worker  Dependant of migrant worker  Seasonal worker  Dependant of seasonal worker  
 Resident

Race:  American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian  
 Other Pacific Islander  Caucasian  Other