



TMH Medical Clinic
(970) 826-2480 office (970) 826-2489 fax
785 Russell Street
Craig CO 81625

Please fill out form completely Child Intake

Child's Legal Name: Last First MI Birth date: ___/___/___ Sex: M or F

Mailing Address: _____

Primary Phone #: _____ SS#: _____

Lives with () Mother () Father () Independent () Other _____

Mother's Legal Name: Last First MI Birth date: ___/___/___

Mailing Address: _____

Primary Phone #: _____ City State Zip Secondary Phone # _____ SS# _____

Father's Legal Name: Last First MI Birth date: ___/___/___

Mailing Address: _____

Primary Phone #: _____ City State Zip Secondary Phone # _____ SS# _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone # _____

Insurance Card Holder's Name: _____ Birth Date: ___/___/___

Address: _____ City State Zip SS#: _____

Employer: _____ Phone #: _____

Health Information can be left:

() Primary # () Secondary # () Other _____ () e-mail _____

Preferred Pharmacy: () City market () K-Mart () 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