



Plano Primary Care Clinic

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PATIENT INFORMATION

Date _____

Name _____ SSN: _____

Address _____ Home Ph: _____

City _____ State _____ Zip Code _____

Sex M F Age _____ Date of Birth _____ Single Married Patient

Employed by _____ Occupation _____

Business Address _____ Business Ph: _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone: _____

DARS EXAM