Patient Identification Form

Identification Information

Today's Date: _____/_____/_____

Name: (last) _____ (first) _____ (middle) _____

DOB (mm/dd/yyyy): _____/_____/_____

Current Address: (street) _____

(city) _____ (state) _____ (zip) _____

Current Phone Number: _____

Email Address: _____

Mother's Name: _____

Father's Name: _____

Emergency contact / alternative way to reach you: _____

_____

Allergies: _____

Medications you are taking: _____

The WCCC distributes a free quarterly WCCC e-newsletter on important health topics and affordable access to health care services, written and distributed by Weill Cornell medical students. Would you like us to send this newsletter to your email address? Yes / No

Please note: All services provided by the WCCC are free of charge to you. However, since all WCCC patients are registered in the New York Presbyterian Hospital system, occasionally a bill is mistakenly generated for one of our patients. If you receive a bill, we ask that you contact the clinic by phone or email so we can quickly remedy the situation. Thank you for your understanding as we seek a permanent solution to this problem.