



Please Note: We Do Not Bill Medical/Health Insurance

Patient Information

Patient Name: _____ Date of Birth _____ Age _____ Gender M F

Guardian (if minor): _____ Relationship: _____

Patient Address: _____

Street Address

City

State

Zip

Contact Information: _____

Home Phone

Mobile Phone

Preferred: __ Home __ Mobile

May we leave a voice message for you on this phone, including medical information? _____ Yes _____ No

Email Address: _____ May we contact you with information? __Y __N

Emergency Contact Information: _____

Name

Phone

Relationship

With whom may we leave a message regarding your medical information? _____ No one

Designated Person Only: _____

Name

Phone

Relationship

May we send you a reminder email, voice mail, or postcard (no medical or personal information)? _____ Yes _____ No

Please tell us how you found out about us:

__ Web site __ Patient Brochure __ Print Ad(s): __ Google/Ads __ Facebook __ Other Social Media

__ Public Presentation __ Work or live in the area __ Referral by physician: __ Referral by patient:

__ Other: _____

Please list any known drug allergies: __ No Drug Allergies

For complete records, we may need to make a copy of a suitable ID (Driver's License).

Signature of Patient

Date

Please complete all pages in this packet