Name: ____
Last *First* *M.I.*

Date of Birth: ____/____/____ Age: _____ SS#: _____________________ Sex: Male Female

Mailing Address: ____
City *State* *Zip Code*

Phone:(____)_______________________ Work Phone: (_____)_________________________________

Cell Phone:(____)________________________ E-mail: ____

Referred by:____ Phone (_____)_________________________

Reason for today's visit:____

Primary Care Physician: ______________________________ Phone (_____)_________________________

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified?______________________ Phone (_____)________________

Relationship to patient: ____

Do you give our office permission to discuss your medical information with family members?

YES NO If yes, please provide their names and phone numbers below.

Name: ____________________________________ Relationship: ___________________________

Phone # (day): (_____)______________________ Phone # (evening): (_____)________________

May we leave personal medical information on your answering machine or cell phone?

YES NO If yes, what number do you prefer that we use? (____)__________________________

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: ____Date of Birth: ____/____/____
Last *First* *M.I.*

Address:____
City *State* *Zip*

Home Phone: (____)______________________ Work Phone: (____)_________________________

Pharmacy Information

Preferred Pharmacy:______________________ Phone Number: (___)_______________

Address:____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signature: ____ Date: ____/____/____