Patient Information

NAME: _____ AGE: _____ DATE of BIRTH _____

HOME ADDRESS_____

CITY _____ STATE _____ ZIP _____

HOME PHONE :_____CELL PHONE : _____

EMAIL: _____

At which number do you prefer to be reached? (circle) Home Cell

May I leave a message? Please circle YES or NO

Any restrictions to messages? (Appointments only, etc). _____

Emergency Contact Name: _____

Relationship to you: _____ Phone: _____

List any medication(s) you are taking (including dosages) and the name(s) of the prescriber(s):

_____

_____

List any medical conditions: _____

_____

Briefly state your presenting problem(s): _____

_____

_____

WHO REFERRED YOU? _____

MAY I THANK THEM? _____

- ❑ **I understand that I may be charged for appointments not canceled 24 hours in advance.**
- ❑ **I understand that I am responsible for fees for services. Outstanding balances on my account may be submitted to collections after thirty (30) days.**

Patient Signature _____ Date _____