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** _____