

Today's Date _____

NAME: _____

First

MI

Last

MAILING ADDRESS: _____

Street

City

State

Zip Code

STREET ADDRESS (if different): _____

Street

City

State

Zip Code

PHONE #1: _____ This is my (circle): cell home work other

It is okay to leave messages regarding my care and upcoming appointments at the above phone number (circle): yes no

PHONE #2: _____ This is my (circle): cell home work other

It is okay to leave messages regarding my care and upcoming appointments at the above phone number (circle): yes no

EMAIL: _____

PLACE OF BIRTH: _____

DATE OF BIRTH: _____

EMPLOYMENT STATUS: Full-time Part-time School Retired Disabled Unemployed Other

OCCUPATION: _____

EMPLOYER: _____

WITH WHOM DO YOU LIVE? (Please list name and relationship and remember to include pets too!)

ARE YOU: Single? Married? Divorced? Widowed? Partnered? Re-married?

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO YOU: _____

PHONE NUMBER: _____

MY CURRENT PRIMARY CARE PROVIDER NAME: _____

LOCATION: _____

MY LAST VISIT WITH MY PCP WAS: _____ I don't have a Primary Care Provider

BLOOD TYPE:

A B AB O Rh+ Unknown

PLEASE LIST ANY ALLERGIES (MEDICINE, FOOD, Etc.) :

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING.

Medication/Supplement (please include brand if you know it)	Amount/Day	Reason for taking

PLEASE LIST OTHER HEALTH CARE PROVIDERS YOU SEE:

Provider Name	Type of practitioner/frequency of visits	Contact information

HOW DID YOU HEAR ABOUT ME? Internet search Health Care Professional Brochure
 Advertisement _____ News Story _____
 Class or Workshop Workplace presentation Fair/Conference Telephone directory
 Another patient/client _____ May I thank them for referring you? Yes No
 Other _____

PLEASE NOTE: Although I do not provide direct insurance billing, **please bring your insurance card** to your visit so that we can make a copy for any laboratory work that you may have done.

THANK YOU!