

Patient Information Form (please print legibly)

Last Name: _____ First Name: _____ MI: _____

Other names/Maiden Name: _____ Date of Birth: _____ Sex: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ SS#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____

Would you like to be on our confidential e-mail newsletter for health tips, classes, & clinic updates? (if yes, please be sure to include your e-mail address above): YES NO

Occupation: _____

Employer: _____ Employer phone number: _____

Mother's Name (minors only): _____

Father's Name (minors only): _____

Emergency Contact: _____ Contact's Phone #: _____

Emergency Contact is my: (specify relationship) _____

Name of Primary Care Physician: _____ Physician's Phone #: (____) _____

Physician's Address: _____

Date of Last Physical Exam: _____

Do you have special needs?: _____

Are you visually impaired? **Yes** **No** Are you hearing impaired? **Yes** **No**

How did you hear about us? (Circle One) Friend/Family Flyer Website

Workshop/Event Medical Referral Newspaper Ad Co-worker Insurance Co.

Other: _____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.

Patient / Guardian Signature

Today's Date