PATIENT HEALTHCARE INFORMATION

TODAY'S DATE:_____

PATIENT NAME:_____ DOB:_____AGE:_____GENDER:_____

ADDRESS:_____CITY:_____STATE:____ ZIP:_____

CELL PHONE:_____ OK TO EXCHANGE TEXT MESSAGES: Y N

PERSONAL EMAIL:_____ OK TO EXCHANGE EMAIL MESSAGES: Y N

HOME PHONE:_____ OK TO LEAVE MESSAGES: Y N

WORK PHONE:_____ OK TO LEAVE MESSAGES: Y N

PATIENT'S WORKPLACE: _____

RELIGIOUS AFFILIATION:_____BY WHOM WERE YOU REFERRED:_____

PARTNER'S NAME:_____DOB:_____AGE:____
(or Parent's Name if Minor)

MOBIL PHONE:_____ OK TO EXCHANGE TEXT MESSAGES: Y N

PERSONAL EMAIL:_____ OK TO EXCHANGE EMAIL MESSAGES: Y N

HOME PHONE:_____ OK TO LEAVE MESSAGES: Y N

WORK PHONE:_____ OK TO EXCHANGE TEXT MESSAGES: Y N

PARTNER/PARENT'S WORKPLACE:_____

PERSON TO CONTACT IN CASE OF EMERGENCY:_____CELL #:_____

Primary Insurance:_____Subscriber:_____DOB:_____

ID#:_____Group/Policy #:_____Phone #:_____

Address:_____

Secondary Insurance:_____Subscriber:_____DOB:_____

ID#:_____Group/Policy #:_____Phone #:_____

Address:_____

Current Primary Care Physician:_____Phone #:_____

Physican/Clinic Address:_____

List all Medications, Suppliments, Herbals & Drugs you are taking/using (including doseages): _____

_____

List present or past major illness, diseases or injuries:_____

_____

List prior therapy, counseling, treatment or hospitalizations:_____

_____

SIGNATURE: _____