PATIENT HEALTHCARE INFORMATION

TODAY'S DATE:___________

PATIENT NAME:______________________________ AGE:_____ DOB:_________ 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 MESSAGE: Y N

WORK PHONE:_______________________________ OK TO LEAVE MESSAGE: Y N

PATIENT'S WORKPLACE: ____

RELIGIOUS AFFILIATION:______________________ BY WHOM WERE YOU REFERRED:______________

SPOUSE'S NAME:____ AGE:_________ DOB:____________

(or Parent's Name if Minor)

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

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

HOME PHONE:__________________________ OK TO LEAVE MESSAGE: Y N

WORK PHONE:__________________________ OK TO LEAVE MESSAGE: Y N

SPOUSE/PARENT'S WORKPLACE:____

SOMEONE TO CONTACT IN CASE OF AN EMERGENCY:_______________________________________

Daytime Phone:_________________ Evening Phone:________________ Cell Phone:___________________

Primary Insurance:______________________________Subscriber:__________________DOB:____________

ID #:_____________________________Group/policy #:_____________________ Phone #__________________

Address:____

Secondary Insurance:____________________________Subscriber:__________________DOB:____________

ID #:_____________________________Group/policy #:_____________________ Phone #__________________

Address:____

Current Physician:_______________________________________Phone:_____________________________

Physician Address:____

List all Medications, Suppliments, Herbals & Drugs you are taking/using:______________________________

____

List present or past major illness, diseases or injuries:

____

____

List prior therapy, counseling, treatment or hospitalizations:

____

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Signature_____________________________________