

PATIENT INFORMATION

Last Name _____ First Name _____ Date _____

Address: _____ Zip Code _____

Telephone: Home _____ Work _____ Cellular _____

Email Address: _____

Age _____ DOB _____ Occupation _____

Who to reach in case of an emergency: _____

How did you hear about our clinic? _____

Are you currently receiving health care? Please circle: Y N

If yes, name of physician: _____

Condition being treated: _____

What are your most important health concerns?

1. _____

2. _____

3. _____

Please list tested or suspected allergies and related symptoms:

Foods: _____

Seasonal: _____

Drug / other: _____

Current Medications: Please list any prescription medications or over-the-counter medications you are taking.

Daily Dosage _____

Do you have a current medical condition(s) (e.g. Epilepsy, Pregnant)? _____

Do you smoke? Please circle: Y N

Please read the New Patient Information form. Sign below when you have finished.

Yes, I have read and understand the items listed on the New Patient Information form.

Signature _____ Date _____
(If under the age of 16, must be signed by Parent or Legal Guardian.)