



**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 \_\_\_\_\_ Contact # \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Are you currently receiving health care? Please circle: Yes No

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.)