Please help us keep your account current and compliant (Thank you for your understanding)

Patient Name:	Date of Birth:
Address (Local):	
Phone: ☐ Home ☐ Cell	
Email address:	
Local Family Physician:	
Medical insurance Information	
If you are not at home do, we have permission to leave a message with personal information? ☐ Yes ☐ No	
Please list the name(s) of the person(s) that have permission to receive medical information or results about you:	
Any Pertinent Medical Changes since your last visit we should know about?	
Reason for your visit today:	
What Medications are you currently taking? **(If you have a list please provide that to the staff)**	
Allergies:	
Have you received your - Flu Shot this season ☐ Yes ☐ No Date: Pneumonia Shot ☐ Yes ☐ No Date:	
Do you use Tobacco? ☐Yes ☐ No Do you drink Alcohol? ☐ Yes ☐ No	
Marital status	

Signature____ Date:____________________________