

PATIENT INFORMATION

This information will be placed in your confidential medical record and will be used exclusively by
PrivaMedis, LLC to facilitate care.

PLEASE PRINT -- THANK YOU!

Last Name	First Name	M.I.

Address	City, State, Zip	

Date of Birth	Name of Spouse/Partner (Full Name)	

Home Phone #	Work Phone #	Cell Phone #

Patient E-mail Address	Pharmacy Name	Pharmacy Phone #

Please indicate your preferred contact phone # (circle one): Home Work Cell

May we leave a detailed message at your preferred phone #? Yes No

In addition to yourself, to whom may we release your medical information?

Please list name (s) and their relationship to you: _____

_____ I prefer that you address any issues related to my medical care only with me.

Do you check your email on a regular basis? Yes No

Do you have dependent children signed up for the practice? Yes No

If yes, list name(s): _____

EMERGENCY CONTACT INFORMATION

Please indicate an alternate contact:

Last Name	First Name	Relationship

Home Phone #	Other Phone #	

_____/_____/_____
Name of individual completing this form **Signature** **Date**

Please complete ALL information and return to the office.