PATIENT INFORMATION Dr. or Practitioner_____

Name_____, _____

M____ F____ date of birth _____/_____/_____

street address_____ city, state,_____ zipcode_____

home phone (_____)_____ work phone (_____)_____

cell phone_____ e-mail address _____

Is patient an adult ____ minor_____ number of siblings _____ number of children _____

Marital status _____ Patient's age _____ height _____ weight _____

Occupation _____ Employed by _____

Work address _____

Spouse/parent _____ occupation_____

Work address _____ Work phone _____

In case of emergency notify _____ relationship_____

work phone _____ home phone _____ Cell _____

Any known medication or supplement allergies? _____

Prescription medications you are currently taking (with dosages): _____

_____

_____

_____

Supplements you are currently taking_____

_____

_____

_____

Other physicians or practitioners who are currently or have recently treated you:

1.Name _____ phone_____

Address_____

2.Name _____ phone_____

Address _____

(continued on next page)

3.Name _____ phone _____

Address _____

4.Name _____ phone_____

Address _____

Objectives for your treatment _____

_____

How did you hear about us? _____

Where did you find our number? _____

If someone other than the patient is responsible for payment please complete the following:

Name of responsible party _____ relationship _____

Employed by_____ work phone _____ Home phone _____

Payment method: cash _____ check _____ Master Card _____ Visa _____

Please read and sign the following:

I, the undersigned, understand that the Center for Complementary Medicine does not file insurance claims, nor does it accept insurance assignments. Payment is expected in full at the time of the visit unless arrangements have been made prior to the appointment, and that payment may be made in the form of cash, check, Master Card, or VISA. I further understand that it is office policy that any cancellation with less than 24 business day hours notice is subject to the full office visit charge. I hereby authorize and request that I/my child be treated by the Center for Complementary Medicine. This authorization remains in effect until it is revoked in writing. The information I have provided is true and accurate to the best of my knowledge. If the information should change during the course of my/my child's treatment, I agree to notify the Center in writing of the changes.

Date_____

Signature_____