Welcome To Our Practice

Patient Name: ______________________________ **Date of Birth:** ______________

Referring Physician or Source: ____

Reason you are seeing us: ____

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Patient's Medical Problems: ____

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Current Medications (include all over the counter medications): ____________________

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Allergies (including medications, food and environmental): _______________________

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Pharmacy Information (include cross streets): ___________________________________

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Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ____________________

Signature of patient (or parent/guardian if minor) **Date**