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PLEASE FILL THIS FORM OUT WITH BLACK INK ONLY

PATIENT INFORMATION:

Date: ____/____/_____

Name: _____ Date of Birth: ____/____/_____
first (middle/maiden) last

Mailing Address:
_____
street city state zip

Marital Status: M S D W Spouse's Name: _____

Home Phone: _____ Work Phone:_____

Cell Phone: _____ Soc Sec No. _____-_____-_____

E-mail address: _____

Employer: _____

Driver's License Number: _____ State:_____

Who is your Primary Care Physician? _____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

***** We are pleased to offer a new patient service feature*** that allows us to communicate with our patients through a secure web-based **E**lectronic **M**edical **R**ecord (EMR). This feature will allow us to send you lab results, appointment reminders, patient education, and other important messages to your personal email account. There is even the opportunity to have access to your secure EMR on-line. We would like all of our patients to take advantage of this unique offer. If you would like to participate in this process please sign and date below:

_____

(Sign and Date here)

I hereby authorize that the above listed information, specifically, my email address, is a valid form of communication for the above listed uses. Thank you for participating.