



Patient Information Sheet

First, M, Last Name _____

Street Address/City/Zip _____

Primary Number _____ Mobile / Home / Work (Circle One)

Secondary Number _____ Mobile / Home / Work (Circle One)

Email _____

Social Security Number _____ Date of Birth _____

Preferred Method of Contact (please circle one) Text Message Phone Email

Preferred Pharmacy (Name and Address) _____

Name of Guardian if patient is under 18 years old _____

Emergency Contact (Name/Number/Relationship) _____

Primary Care Provider _____ Specialist(s) _____

Personal Medical History
Known Drug Allergies:
Medication List:
Personal History: Heart Disease Diabetes Cancer Cholesterol Stroke Seizures Hypertension Lung Disease Genetic Disorder Mental Disorder Blood Disorder Other:
Immediate Family History:
Social History: Single Married Divorced Widowed Children Smoking Alcohol

Insurance Through:

<input type="checkbox"/> DPC-Consumer	<input type="checkbox"/> WFL Employee
<input type="checkbox"/> Greater Clark County School Corporation	<input type="checkbox"/> Other