LEGACY
HEALTH & WELLNESS
VEIN.HORMONE.SPECIALISTS.

Patient Information

Name (First) _____ **(MI)** _____ **(Last)** _____ **DOB** ___/___/_____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____

Is it OK if we send you messages via text? ☐ Yes ☐ No

Email Address _____

Would you like to be added to our newsletter database? (may opt out anytime) ☐ Yes ☐ No

Sex ☐ Male ☐ Female **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation _____ **Employer**_____ **Work Phone** _____

Preferred Pharmacy _____ **Phone** _____

Spouse Information

Name _____ DOB ___/___/_____

Occupation _____ Employer_____ Work Phone _____

How did you find out about us?

□ Referral from Physician _____
□ Friend or Family Member _____
□ Radio _____
□ TV _____
□ Internet _____
□ Other _____

Physician that Referred You:

Name _____ Specialty _____ Phone _____

Address _____ City _____ State _____ Zip_____

Primary Care Physician (if other than referring physician):

Name _____ Specialty _____ Phone _____

Address _____ City _____ State _____ Zip_____

In Case of Emergency, Contact _____ **Phone**_____
Relation to: _____

I hereby consent to evaluation, testing, and treatment/procedures that are provided to me or the patient for whom I am responsible. This would include all providers, nurses, and interns that are affiliated with Legacy Health & Wellness.

Patient Signature: _____ **Date:** _____