Patient Information

Name (First) _____ (MI) _____ (Last) _____

Address _____Apt_____

Email Address _____ DOB ___/___/___ Social Security _____-____-_____

Sex ☐Male ☐Female Marital Status ☐S ☐M ☐D ☐W

Occupation _____ Employer_____

Work Phone _____ City_____ State_____

Spouse Information:

Name _____ DOB ___/___/___ Social Security _____-____-_____

Occupation _____ Employer_____

Work Phone _____ City_____ State_____

How did you find out about us?

☐ Referral from Physician _____ ☐Friend/Family Member _____

☐ Radio Station_____ ☐TV Station_____ ☐ Internet Site_____ ☐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_____

Preferred Pharmacy: _____

In Case of Emergency, Contact _____ Phone_____

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 doctors, nurses, and interns that are affiliated with Legacy Health & Wellness.

Signature: _____ Date: _____