

## Patient Information (confidential)

Patient Name Mr/Mrs/Ms/Dr/Rev \_\_\_\_\_

Preferred Name \_\_\_\_\_ Preferred Pronoun \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: Male / Female Home/Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City/St./Zip \_\_\_\_\_

Employer's Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Please supply your email address for AHB communication purposes only. This address will not be shared without your consent. \_\_\_\_\_

Preferred method of contact: email \_\_\_\_\_ cell \_\_\_\_\_ home \_\_\_\_\_ work \_\_\_\_\_  
(OK to leave message at selected number - Y N)

Spouse (or parent) \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact (not living with you) \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone \_\_\_\_\_

Can we discuss your medical health; Y N and/or billing information; Y N with anyone other than you?

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Whom May We Thank For Referring You? \_\_\_\_\_

Primary Care Physician & Location \_\_\_\_\_ Phone \_\_\_\_\_

Do you have a **follow up appointment** scheduled with a physician regarding today's visit? Yes / No

If yes, with who? \_\_\_\_\_ Location \_\_\_\_\_

Phone \_\_\_\_\_ Appointment **Date & Time** \_\_\_\_\_