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PATIENT INFORMATION FORM

Name:____Date of Birth:__________________

Please indicate the name(s) and telephone numbers of anyone you wish contacted in the event of an emergency and with whom your personal health information may be shared:

____

____

Your Mailing Address:____

Can we send mail to this address? Yes ___ No ___

Telephone Number(s):____________________________ ___________________________________

Can we leave confidential messages (i.e. appt reminders, etc) on your telephone answering machine or voicemail? Yes___ No____

e-mail: _______________________________Can we contact you by e-mail? Yes___No___

Western Medical Primary Care Physician:____

Telephone Number:__________________________________

Date of Last Western Medical physical examination:_____________________________

____ ____________

Patient Signature (or Guardian if patient under 18) **Date**