Welcome to Our Practice

Patient name_____**Date of Birth**_____

Referring Physician or Source_____

Reason you are seeing us_____

Patient's Medical Problems_____

_____

_____

Current Medications (include over the counter)_____

_____

_____

Allergies (including medications, food, and environmental) _____

_____

_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of patient (or parent/guardian if minor) **Date**