

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: ☐ Text Message ☐ Email ☐ Voice call – Home | Cell | Work
(OK to leave message at selected number - ☐ Yes ☐ No)

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** _____