Patient Health History

Today's Date: _____/_____/_____ Signature of Patient: _____

Patient Title: (*check one)* ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev.

First Name: _____ Nick Name: _____

Last Name: _____ Middle Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ 2nd Phone: _____ Cell: _____

Home email: _____ Work email: _____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Which email address would you like us to use to communicate with you? ☐ Home ☐ Work

Each year, we send out a few marketing emails, including our free treatment day information. Please initial if you would NOT like to receive these emails. _____

Preferred Contact Method:

☐ Primary Phone ☐ 2nd Phone ☐ Cell Phone ☐ Home Email ☐ Work Email

Date of Birth: ____/____/____ Age: _____ Gender: ☐ Male ☐ Female

How did you find us? ☐ Google ☐ Yelp ☐ Internet Search ☐ Drive-By ☐ Referral

If referred, by whom? _____ ☐ Other: _____