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Patient Information Form

This information enables me to gain a better understanding of you and your concerns. It will become a part of your confidential record. Please answer each question as completely as possible.

Personal Information		
Your Name:		
Date of Birth:		
Address:		
Phone:		
Email:		
Do I have your permission to contact you by phone and email?	Yes	No
Do I have permission to send you appointment notices by email?	Yes	No
Race/Ethnicity:		
Who should I contact in case of an emergency? Name: Relationship: Phone:		

My signature below indicates the information I have provided is accurate and complete.	
Your Name Printed	Date
Your Signature	Date