Date ________________

Please fill out this form (or have your caregiver complete it) and discuss it with your medical provider. Thank you!

Patient Name ____ Date of Birth _____________________________
Home Phone ______________________ Cell Phone ______________________ Work Phone ______________________
Address ____City ________________________ State _____ Zip _________
Email Address ____
Emergency Contact _______________________________ Relationship __________________ Phone ________________
Pharmacy _________________________________ Address/City ____
Mail Order Pharmacy _________________________________ Phone ____

Race: American Indian or Alaska Native Asian or Pacific Islander Black Hispanic White Declined Unknown	
Ethnicity: Hispanic Non-Hispanic Declined Unknown	**Preferred Language:**

How would you like to receive your healthcare **Reminders:** CELL PHONE HOME PHONE WORKPHONE MAIL DECLINE
Reminders will be in your Patient Portal account if/when you sign up as well

Allergies

Name of Substance (drug or food)	**Type of Reaction**
☐ Check if none	

Current Medications

Prescription Drugs (such as Lipitor, eye drops, creams)	**Strength** (such as 50 mg)	**Directions** (such as 2 tablets in the am) *Check box if taken only as needed.*		**Prescribed by** (such as John Doe, MD)
☐ Check if none			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	

Over-the-Counter Medications (such as Aspirin)	**Strength**	**Directions** (such as for headaches, when needed)
☐ Check if none		
Herbs, Vitamins, Minerals, Etc. (such as St. John's Wort)	**Strength**	**Directions** (such as one tablet each day)
☐ Check if none		