Patient Demographics

Basic Information			
First Name		***Home Phone***	
Middle Initial		***Work Phone***	
Last Name		***Cell Phone***	
Date of Birth		***Email***	
Sex		***Circle Preferred Correspondence: EMAIL or POSTAL***	
Race		***Preferred Language***	
Circle: Hispanic or Not Hispanic		***Marital Status***	
SSN		***Employer Name***	
Mailing Address		***Name of Insurance***	
		Member ID	
		Copay (ov / pcp)	
Do you have any family members who are patients in this practice?			
Name		***Relation to Patient***	
Name		***Relation to Patient***	
*******Pharmacy********		***Emergency Contact***	
Pharmacy		***Name***	
Phone		***Phone***	
Address		***Relationship***	
City, State, Zip		***Address***	
		City, State, Zip	
If applicable Name of Mail In Pharmacy :			

I wish to be contacted in the following manner (Check all that apply):

Primary Telephone: (___) ____ - _____
- ☐ OK to leave message with detailed information
- ☐ Leave a message with call-back number only

Secondary Telephone: (___) ____ - _____
- ☐ OK to leave message with detailed information
- ☐ Leave a message with call-back number only

Who else you may discuss my health with: I authorize The Center for Integrative Health (CIH) to discuss with and release to the following any and all of my personal health information, should CIH not be able to reach me or in case of an emergency.

Name _____Relationship _____ Phone Number _____

This practice requires 24 hour notice for all cancellations. I understand that failure to do so will result in a $25.00 fee for missed office visits and a $50.00 fee for missed physicals/well exams.

This authorization will remain in effect until written notification is given to CIH.

_____ _____

Patient Signature **Today's Date**