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YF&A

UPDATED PATIENT INFORMATION

PATIENT NAME: _____ _____ _____ DATE OF BIRTH: ____/____/_____ SEX: M / F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE #: (____) _____ - _____ WORK PHONE #: (____) ____ - _____ SSN#: _____ - _____ - _____

CELL PHONE #: (____) _____ - _____ E-MAIL: _____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) _____ - _____

PRIMARY CARE DOCTOR: _____ PHONE #: (____) _____ - _____

PHARMACY: _____ LOCATION: _____ PHONE #: (____) _____ - _____

PRIMARY INSURANCE: _____ID #: _____ GROUP #: _____

RELATIONSHIP TO INSURED: _____ **PROVIDE NAME & DOB, IF NOT SELF** :_____

SECONDARY INSURANCE: _____ ID #: _____ GROUP #: _____

SHOE SIZE: _____ HEIGHT: _____ WEIGHT: _____

PLEASE LIST ALL **MEDICATIONS** YOU ARE CURRENTLY TAKING: _____
_____
_____

PLEASE LIST ANY **ALLERGIES** YOU HAVE : _____
_____
_____

I AUTHORIZE DR. YEARGAIN TO RELEASE ANY MEDICAL INFORMATION FOR PURPOSES OF DISABILITY, OR PROCESSING INSURANCE CLAIMS RELATED TO SERVICE. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO DR. YEARGAIN FOR THE PERFORMANCE OF SERVICES. I ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: _____