Date_____

Last Name_____First Name_____Middle Name_____

Name I prefer to be called_____

Address _____City/Town_____

State_____Zip_____

Phone 1 Circle One: Home, Work, Cell_____

Phone 2 Circle One: Home, Work,Cell_____

Place of work and full address_____

_____position_____length of time_____

Gender_____Marital Status_____Date of Birth_____

Birth Place_____Race_____Religion_____

Provide identification-(circle one) Social Security Card, Drivers' License, *or* Passport
ID number_____

Primary Care Doctor's Name, Address, Phone, Fax:

_____
_____
_____
_____
_____

Other doctors, therapists, clinics-with Address, Phone, Fax:

_____
_____
_____
_____

All medications:

Name	**Mg per pill**	**Frequency/time**	**Reason for taking**

_____
_____
_____
_____
_____

continue on back if need more space.

Medication continued:

Name	**Mg per pill**	**Frequency/time**	**Reason for taking**

Name, Address, Emergency Phone Number for significant other, relative or close friend
Note if information may be given in an emergency.

Name_____**Relationship**_____
Address_____**City/Town**_____
State_____**Zip**_____**Permission to give emergency info Yes/ No**
Name_____**Relationship**_____
Address_____**City/Town**_____
State_____**Zip**_____**Permission to give emergency info Yes/ No**

All information is complete and true to the best of my knowledge

_____

signature **date**

HIPPA/Privacy Policy

Your health information may be used to coordinate and manage care with your other physicians, therapists, pharmacies and laboratories. Otherwise your information will not be given to others in any other situation, unless we have concerns about your safety or the safety of others, without your specific consent.

I have read the privacy policy and I consent to evaluation and treatment by Mr Woodard.

_____

signature **date**