Patient Information

Name: _____ □ Jr. □ Sr.
Last First Middle Initial

Address: _____
Street# Street Name Apt #

_____
City State Zip

Home Phone: _____ Cell Phone: _____

Alternate Address: _____

Alternate Phone: _____

Date of Birth: _____/_____/_____
Month Day Year

Social Security Number: _____ Sex: □ Male □ Female

e-mail: _____

Occupation: _____

Employer: _____
Name Address

Are you under the care of a Primary Care Physician? YES NO

If yes, Physician's name: _____

Phone: _____ Fax: _____

Emergency Contact: _____Phone#:_____ Relationship:_____

How did you learn about this practice? _____

Do you have a living will? □ YES □ NO (We will keep a copy on record at your request)

Do we have your permission to:

Leave a message on your voicemail? □ YES □ NO

Discuss your medical condition with someone beside you? □ YES □ NO

(Please Note: a message can be left only if your name is stated on your voicemail)

If yes, whom: _____ Relationship _____

"I give Cynthia Hensley, M.D. and her staff permission to examine and treat."

_____ _____
Signature of patient or patient's legal guardian Date