AUTHENTIC HEALTH D.O. LLC

Patient Information

Basic Info:

Last Name*:	First Name:*	Middle Initial:
If minor, name of adult responsible:		
DOB*:		Drivers license #*:
Home Address:		
City:	State:	ZIP code:
Home #:	Mobile #:	Email:
Preference for contact (Select one): Home Number (Call) Mobile Number (Call and Text)		
Were you referred to us? (Select one): YES NO		
If Referred, please enter NAME:		
If Referred, please enter Address OR Phone Number:		
Emergency Contact Name (1):		
Address:		Phone:
City:	State:	ZIP code:
Who can we share your information with?		

Past surgeries:
Allergies:
Documented conditions/illnesses:
Current prescriptions/supplements:
Previous treatments you've tried before:

Patient Signature: _____ Date: _____

(If Applicable)
Patient Representative/Parent: _____ Date: _____
***Note: If you are representing someone as their POA, documentation of your POA status must be provided prior to treatment.*

(If Applicable) For patients requiring translation or verbal reading of document:

Reader/Translator: _____ Date: _____