PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: **Age**		**Gender: M F**
How did you hear about us?		
Physical Address		**Mailing Address**
Phone Numbers: **Home:** **Work:** **Cell:**	**OK to call?** **H:** **W:** **C:**	**OK to leave message?** **H:** **W:** **C:**
May we send text message reminders of your appointment time to the numbers listed above? By marking "Yes" you acknowledge that text messages may NOT be secure, with a risk of unauthorized to access to your information. YES_____ NO_____		
May we send you emails related to your care with us? YES_____NO_____ **By providing your e-mail address below you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.** **EMAIL: _____**		
Are you currently receiving or have you received any other therapy services the last 60 days? YES_____ NO_____		
Marital status		
Student status □full time □part time □none		
Emergency contact:		

Name:	**Phone/ cell**	**Work phone**	**Type of contact**

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name_____ Relationship_____

Name_____ Relationship _____

Signature of patient_____Date_____