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(919)416-0675

PATIENT INFORMATION FORM

Name:_____Date of Birth:_____

Please indicate the name(s) and telephone numbers of anyone you wish contacted in the event of an emergency and with whom your personal health information may be shared:

_____

_____

Your Mailing Address:_____

Can we send mail to this address? Yes ___ No ___

Telephone Number(s):_____ _____

Can we leave confidential messages (i.e. appointment reminders, etc) on your telephone answering machine or voicemail? Yes___ No ___

Western Medical Primary Care Physician:_____

Telephone Number:_____

Date of Last Western Medical physical examination:_____

_____ _____
Patient Signature (or Guardian if patient under 18) **Date**