PATIENT INFORMATION

This information will be placed in your confidential medical record and will be used exclusively by **Michelle Evans, MD** to facilitate care.

PLEASE PRINT -- THANK YOU!

_____ _____ _____
Last Name **First Name** **M.I.**

_____ _____
Address **City, State, Zip**

_____ _____
Date of Birth **Name of Spouse/Partner (Full Name)**

_____ _____ _____
Home Phone # **Work Phone #** **Cell Phone #**

_____ _____ _____
Patient E-mail Address **Pharmacy Name** **Pharmacy Phone #**

Please indicate your preferred contact phone # (circle one): **Home Work Cell**

May we leave a detailed message at your preferred phone #? **Yes No**

In addition to yourself, to whom may we release your medical information?

Please list name (s) and their relationship to you: _____

_____

_____ I prefer that you address any issues related to my medical care only with me.

Do you check your email on a regular basis? **Yes No**

Do you have dependent children signed up for the practice? **Yes No**

If yes, list name(s): _____

EMERGENCY CONTACT INFORMATION

Please indicate an alternate contact:

_____ _____ _____
Last Name **First Name** **Relationship**

_____ _____
Home Phone # **Other Phone #**

_____/_____/_____
Name of individual completing this form **Signature** **Date**

Please complete ALL information and return to Michelle Evans, MD.