PATIENT INFORMATION

This information will be placed in your confidential medical record and will be used exclusively by **NOVAMED Associates, PC** 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 the office.