Copper Valley Medical
Caring, Compassionate Healing

Please Note: We Do Not Bill Medical/Health Insurance

Patient Information

Patient Name: _____ Date of Birth_____ Age _____ Gender M F

Guardian (if minor): _____ Relationship: _____

Patient Address: _____
Street Address

_____
City State Zip

Contact Information: _____
Home Phone Mobile Phone Preferred: __ Home __Mobile

May we leave a voice message for you on this phone, including medical information? ___ Yes ___ No

Email Address: _____ May we contact you with information? __Y __N

Emergency Contact Information: _____
Name Phone Relationship

With whom may we leave a message regarding your medical information? ___ No one

Designated Person Only: _____
Name Phone Relationship

May we send you a reminder email, voice mail, or postcard (no medical or personal information)? ___Yes ___ No

Please tell us how you found out about us:
__ Web site __ Patient Brochure __ Print Ad(s): __ Google/Ads __Facebook __ Other Social Media

__ Public Presentation __ Work or live in the area __Referral by physician: __Referral by patient: _____

__Other: _____

Please list any known drug allergies: __ No Drug Allergies

_____ _____ _____

_____ _____ _____

For complete records, we may need to make a copy of a suitable ID (Driver's License).

Signature of Patient

_____ _____
Date

Please complete all pages in this packet

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