J.LOPEZ, M.D.
Medical Group Inc.

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Patient's Information Sheet

DATE: _____

Please provide your information in the fields below. To help ensure the best quality of service, be as accurate as possible with the information you provide.

PATIENT'S NAME: (Last)_____
(First) _____ MR. ☐ MRS. ☐ MS. ☐

AGE: _____ DATE OF BIRTH(DD-MM-YYYY): _____ GENDER: Female

HOME ADDRESS:

_____
___ (STREET)

_____
___ (CITY) (STATE) (ZIP CODE)

CONTACT INFORMATION:

HOME PHONE #: (_____)_____ MOBILE #: (_____
)_____

EMAIL ADDRESS: _____

EMPLOYER: _____

OCCUPATION: _____ WORK PHONE #: (_____)
_____

EMPLOYER'S ADDRESS:

_____

SPOUSE (If applicable): _____ CONTACT NO. #: (_____)
_____

NO. OF CHILDREN: _____

PATIENT'S NEAREST RELATIVE: _____

RELATION TO PATIENT: _____ PHONE #: (_____) _____

PHYSICIAN: _____ DATE OF LAST PHYSICAL: _____

DENTIST: _____ DATE OF LAST CHECK-UP: _____

WERE YOU REFERRED TO OUR CLINIC? No

IF YES, WHO REFERRED YOU? _____

PHONE #: (_____)_____

NAME OF MEDICAL INSURANCE (If applicable):

_____

IF PATIENT IS A MINOR, WHO IS THE LEGAL GUARDIAN RESPONSIBLE?

_____

WHOM TO CONTACT IN CASE OF EMERGENCY?

_____

DUE TO OUR BUSY SCHEDULE, OUR OFFICE CANCELLATION POLICY IS 48 HOUR (2 BUSINESS DAYS) IN ADVANCE. WITHOUT CANCELLING YOUR INITIAL NEW PATIENT APPOINTMENT WITHIN 48 HOURS THERE IS A FEE OF THE FULL APPOINTMENT RATE.THANK YOU FOR YOUR UNDERSTANDING. ACKNOWLEDGEMENT: I acknowledge full responsibility for the accuracy of the information provided within the forms, payment of services and agree to pay in full, at the time of service unless other arrangements have been made with the office in writing.

_____

PARENT OR GUARDIAN'S SIGNATURE

_____

PATIENT'S SIGNATURE

_____

DATE

_____