

Phone 269-254-8130 | Fax 866-376-0467

www.santoshawellnesskzoo.com

**Patient Information**

|  |
| --- |
| Name: |
| Birthdate (mm/dd/yyyy): | Sex: ( ) Male ( ) Female  |
| Diagnosis:  |
| Physician Name: |
| Physician Office: |
| Reason for Referral:  |
| Would you like to receive text/email appointment reminders? ( ) Yes ( ) NoIf yes, provide your preferred number/email:  |

**Parent/Caregiver Information**

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| --- |
| Parent #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) Mom ( ) Dad ( ) Foster Parent ( ) Other \_\_\_\_\_\_\_\_\_Parent #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) Mom ( ) Dad ( ) Foster Parent ( ) Other \_\_\_\_\_\_\_\_\_ |
|  Is your child adopted? ( ) Yes ( ) No  | Who does the child live with?: \_\_\_ Parent #1 \_\_\_ Parent #2 \_\_\_ Both Please explain the living situation (*if not living with both parents):*  |
| Address:  |
| Preferred Phone: Name:  |
| Alternate Phone: Name: |
| Preferred Email: |

**Emergency Contact Information**

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| --- |
| Name: |
| Address:  |
| Phone: |
| Relationship to Patient:  |