

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 ( ) No  If yes, provide your preferred number/email: | |

**Parent/Caregiver Information**

|  |  |
| --- | --- |
| 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: |