Millar
Functional Medicine

PATIENT LABEL

PERSONAL INFORMATION

Today's Date:_____/_____/_____ Date of Birth:_____/_____/_____ Age:_____□ Male □ Female

PERSONAL INFORMATION

Patient Name (Last, First, MI): _____

Address: _____

City: _____State: _____Zip: _____

Drivers Lic Number: _____State_____Social Security # _____ -_____- _____

□ Married □ Single □ Widowed □ Divorced Spouse/Significant other's Name: _____

Home Phone:( ) _____- _____ Work Phone:( ) _____- _____

Your Cell Phone:( ) _____- _____ □ yes □ no Text or leave health messages on this phone

Spouse Cell Phone:( ) _____- _____

This is the email address you want the Doctor to use to contact you personally

Private E-mail address: _____

Occupation: _____ How many years _____

□ Yes you may send me other treatment info about my conditions and put me on monthly newsletter

EMERGENCY CONTACT INFORMATION In case of emergency please contact:

Name: _____ Relation: _____

Address: _____

Cell Phone: ( ) _____- _____ Home Phone: ( ) _____- _____

Second emergency contact: _____ Cell Phone ( ) _____- _____

I hereby give my permission to contact the above named person(s) and fully discuss my condition.

Signed _____ Date _____

INSURANCE – Insurance doesn't cover Functional Medicine; but, it may cover some blood test.

Insured's Name: _____ Insured's SS# _____

Relation: _____ Their DOB _____

Insurance Company: _____Policy #: _____

Primary Insurance: _____ Secondary Insurance: _____