Name____Date_____________________________

Emergency Contact: Name/Phone ____

Do you have a caregiver? YES or NO

If Yes: Name_______________________________ Phone______________________________

Relationship: ___________________________

If you have a caregiver, do we have a signed HIPAA form allowing us to speak with them? YES or NO
If NO, please complete a HIPAA form during your visit if you would like us to be able to speak to them about your care.

PLEASE LIST ANY SPECIALISTS THAT YOU SEE:

	Name of Doctor/Address /Phone	Last Visit	Check if Self-Referred
PODIATRY (Foot Doctor)			☐
OPHTHALMOLOGY (Eye Doctor)			☐
CARDIOLOGY			☐
ORTHOPEDICS			☐
GASTROENTEROLOGY			☐
RENAL/KIDNEY (NEPHROLOGY)			☐
UROLOGY			☐
PSYCHIATRY (Prescribes Meds)			☐
PSYCHOLOGY (Talk Therapy)			☐
RHEUMATOLOGY			☐
NEUROLOGY			☐
DERMATOLOGY			☐
ENDOCRINOLOGY			☐
ALLERGIST			☐
GYNECOLOGY			☐
ENT (Ear/Nose/Throat)			☐
PAIN MANAGEMENT			☐
OTHER(S)			☐