9 COMMONS STREET,
RUTLAND, VT 05701
(802) 779-7522 Fax: (802) 735-9662

PATIENT CONTACT INFORMATION

This information will be placed in your confidential medical record and will be used exclusively by the medical practice to facilitate your care.

Please PRINT - thank you!

_____ _____ _____
Last Name First Name M.I.

_____ _____
Address City, State, Zip

_____ _____
Date of Birth Your Email Address or that of a trusted contact

_____ _____ _____
Home Phone # Work Phone # Cell Phone #

Please indicate your preferred contact phone # *(circle one)*: Home Work Cell

May we leave a detailed message at your preferred phone #? Yes No

_____ _____ _____
SPOUSE / PARTNER Last Name First Name Phone #s

_____ _____ _____
LEGAL GUARDIAN Last Name First Name Phone #s

_____ _____ _____
Other Contact for DEPENDENT Adult Last Name First Name Phone #s

_____ _____ _____
EMERGENCY ONLY CONTACT Last Name First Name Phone #s

May we release your medical information to anyone listed above? If yes, who?

_____

May we leave medical information with anyone if unable to reach you? If yes, who?

Please list your medical health insurance and policy #; *please present your insurance card(s) at your 1st visit*

Name _____ Policy #_____

Name _____ Policy #_____

[ ] I acknowledge, that I have received the Notice of Privacy Practice document. Please Initial _____