
**Today's Date: _____**

**Last Name: _____ First Name: _____MI: ___**

**Preferred Name**: _____ **Age: ____ Birth-date ____/_____/____ How did you hear about us? _____**

**Street Address: _____**

**City: _____ State: _____ ZIP: _____**

**Cell Phone**: _____ **Home Phone: _____**

**E.mail: _____**

**Gender: Male_____ Female_____ Primary Language: _____**

**Race**: [ ] American Indian/Alaska Native [ ] Asian [ ] Black/African-American [ ] Native Hawaiian/Pacific Islander [ ] White/Caucasian [ ] Multi-Radial Decline [ ]

**Marital Status:** Married [ ] Single [ ] Partnered [ ] Widowed [ ] Name of Partner/Spouse/Significant Other _____

Do you have a Primary Care Provider? Yes [ ] No [ ] If yes, Name: _____

**Address**: **Phone:**

**Patient Employed by**: _____

**Business Address**: _____

**Business Phone: _____ Occupation: _____**

**Name of Guardian/Responsible Party (If patient is minor):**

_____ _____
Last First

**In case of an emergency, who should be notified? Name**: _____

Relationship _____ Phone: _____

Address: _____

OPTIMAL HEALTH CLINIC

*Where optimal care and affordability meet*

**Privacy Practices**

I understand that Optimal Health Clinic has a policy that governs the disclosure of patient health information, as well as how patient may access their information. This policy is provided upon initiation of service or at patient's request. I may obtain a copy of my medical record at my own expense and upon my execution of an Authorization for Release of Medical Records Form.

_____

Name Signature Date

**Financial Agreement**

I the undersigned person hereby acknowledge that Optimal Health Clinic does not accept medical insurance and all payments are due at the time of service.

Print Name: _____

_____ _____

Signature of Patient/Legal Guardian Date

**Consent for Treatment**

I (or my legal guardian/parent) authorize Optimal Health Clinic to provide medical care reasonable by today's standards. I also understand that if I am referred to a specialist, I will have to follow up to be continuously seen at this practice.

_____ _____

Signature of Patient/Legal Guardian Date

**Personal Valuables & Accompanying Individuals**

I understand that Optimal Health Clinic is not responsible for the loss or damage to items. I also understand that any individual or family member accompanying me to Optimal Health Clinic must obey all the posted rules. The clinic may remove myself/other individual from the premises and/or deny myself/other individual services.

_____ _____

Signature of Patient/Legal Guardian Date

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**Name:** _____ **Date of Birth:** _____

# Medication List

| Medication | Dosage | Last Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# Allergies

| Medication | Reaction |
|---|---|
| | |
| | |
| | |

**Pharmacy:** _____ **Location:** _____