Patient Name____

First Name Used ________________ Legal Sex___________________________

DOB__________________________ Social Security Number __________________

Address____

City___________________________ State____________ Zip________________

Home Number____________ Cell Number____________ Email _________________

Do we have consent to call?_______ Text?___________ Leave voicemail?__________

Patient Race___________________ Marital Status____________________________

Do we have permission to obtain your pharmacy history?____ Pharmacy _______________

Emergency Contact Name/Relation to Patient ____________________________________
Emergency Contact Number____

Emergency Contact Name/Relation to Patient_____________________________________
Emergency Contact Number____

Patient Employer Name/Number____

PATIENTS UNDER 18 YEARS OF AGE:

Guarantor____

Guarantor Relationship to Patient ____

Guarantor Address____

Guarantor Phone Number____

Guarantor DOB______________________ Guarantor SS # __________________________

I have read the attached consent to treatment and have reviewed a copy of Infinity Family Care Patient Rights and Responsibilities ____________________________Date ________________