CarolinaClinic FOR HEALTH & WELLNESS
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Patient Information

Date: _____ *(Please print)*

Patient Name: _____
(Last) *(First)* *(Middle)*

Sex: M F Date of Birth: _____ SSN: _____

Address: _____
(Street) *(City)* *(State)* *(Zip)*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Contact Preference: _____

Marital Status: S M D W Employer: _____ Phone: _____

Preferred Pharmacy: _____ Preferred Lab: _____

Primary Care Provider: _____

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Guarantor/Responsible Party Information

Responsible Party Name: _____
(Last) *(First)* *(Middle)*

Relationship to Patient: _____

Sex: M F Date of Birth: _____ SSN: _____

Address: _____
(Street) *City)* *(State)* *(Zip)*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Contact Preference: _____

Marital Status: S M D W Employer: _____ Phone: _____

I certify that the above information is correct and I consent to treatment necessary for the care of the above-named patient.

X _____ Date: _____
Signature of patient or person acting on patient's behalf