Print Clear Form

absolute health

8360 E. Raintree Dr. Suite 135
Scottsdale, AZ 85260
(480) 991-9945

New Patient Information

Last Name _____ First Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Telephone: Home _____ Cell _____ Work _____

Date of Birth _____ Age _____ Email Address _____

How would you like to be contacted from Absolute Health? _____ Phone _____ Email

Employer _____ Occupation _____

Emergency Contact Name _____Phone Number_____ Relation_____

Who referred you to Absolute Health? _____

Please select: Female (●) Male ( ) Please select: Married ( ) Divorced ( ) Separated ( ) Single ( ) Widowed (●)

List your health problems in order of importance:

1) _____
2) _____
3) _____
4) _____
5) _____

Medical conditions you have been diagnosed with: _____
_____
_____

Medical conditions that run in your family: _____
_____
_____

Medications you are taking: _____
_____
_____

Supplements/vitamins you are taking: _____
_____
_____

Allergies to medications or foods: _____

Are you or your companion trying to conceive? YES ◯ NO ◉

Date of most recent lab work: _____

Expectations for today's visit: _____
_____
_____
_____

The clinic has a 24-hour cancellation policy. Late cancellations or noshows will incur a charge of $35.00.Please arrive 10 minutes prior to your appointment time. Late arrivals may be rescheduled and will incur a charge of $35.00. Payment is due at the time services are rendered. I certify this information to be true and correct. I assign my benefit payments to be paid directly to Absolute Health LLC. However, I understand that I am ultimately responsible for payments of services rendered. I also authorize the release of any information which is required for payment.

_____	_____	_____
Patient or Guardian Signature	Date	Witness