



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 spouse/companion trying to conceive(become pregnant) now or in future? 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