AcuProlo Institute

Integrative Health Management
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(310) 878-2874 • www.acuprolo.com

PATIENT CONFIDENTIAL INFORMATION

First name:_____Middle:_____Last name:_____DOB:_____

Home address: _____City:_____State:_____ Zip:_____

Mailing address: _____City:_____State:_____Zip:_____
□ Same as home address

Home Phone:(_____)_____Work:(_____)_____Cell: (_____)_____

Email:_____
What is the best way to contact you? □ By email □ Home phone □ Work phone □ Cell phone

Can messages containing personal health-related information be left on your:
Email? □ Yes □ No Home phone? □Yes □ No
Work phone? □ Yes □ No Cell phone? □ Yes □ No

Marital Status: □ Single □ Married □ Divorced □ Widowed
Is it OK to disclose to your spouse your personal health-related information? □ Yes □ No

Is there anyone else whom you authorize for us to share your personal health related information with?
□ No □ Yes, the following people:
Name_____Relationship to you:_____

Name_____Relationship to you:_____

Occupation: _____ Employer:_____

Work address: _____City:_____ State:_____ Zip:_____

Primary Care Provider: _____Phone: (_____)_____

Address:_____City:_____State:_____ Zip:_____

Emergency Contact person:_____Relationship to you: _____

Home Phone:(_____)_____Work:(_____)_____Cell: (_____)_____

Alternate Contact person::_____Relationship to you: _____

Home Phone:(_____)_____Work:(_____)_____Cell: (_____)_____

I certify that the information on this Patient Information Form is true and correct to the best of my knowledge. I agree to notify the office of any changes in my personal contact information. I also certify that I am aware I can review the Patient Bill of Rights and Privacy Practices on line at www.acuprolo.com and upon my request I can receive a hard copy.

_____ _____
Patient Signature Date