PATIENT INFORMATION

This information will be placed in your confidential medical record and will be used exclusively by the medical practice of **Caroline K. Stratz, MD** to facilitate care.

PLEASE PRINT -- THANK YOU!

Last Name _____ **First Name** _____ **M.I.** _____

Address _____ **City, State, Zip** _____

Date of Birth _____ **Name of Spouse/Partner (Full Name)** _____

Home Phone # _____ **Work Phone #** _____ **Cell Phone #** _____

Patient E-mail Address _____ **Pharmacy Name** _____ **Pharmacy Phone #** _____

Please indicate your preferred contact phone # (circle one): **Home Work Cell**

May we leave a detailed message at your preferred phone #? **Yes No**

May we release your medical information to your spouse/partner? **Yes No**

Do you check your email on a regular basis? **Yes No**

May we send health information by email? **Yes No**

Do you have dependent children signed up for the practice? **Yes No**

If yes, list names: _____

EMERGENCY CONTACT INFORMATION

Please indicate an alternate contact:

Last Name _____ **First Name** _____ **Relationship** _____

Home Phone # _____ **Other Phone #** _____