



Confidential patient information

Name _____ Birth Date ___/___/___ Age ___ Date _____

Address _____ City _____ Zip _____

Phones: Home _____ Work _____ Mobile _____

Social Security # _____ E-mail (confidential) _____ fax _____

Occupation _____ Employer _____

Circle one: Single, Married, Divorced, Separated, Significant relationship/ Name of Spouse/Partner

Emergency Contact:

Name _____ Relationship to you _____ Phone _____

How did you hear about Dr. Aidun? _____

What is the main reason for today's office visit? _____

Your pharmacy: _____ **phone number:** _____

Patient record of disclosure

Please choose **Yes** or **No** to the following and **initial**: I authorize employees or physicians at **natural solutions for women** to leave a **detailed message** for me on a voice message device associated with the phone number listed below:

- 1) Laboratory reports Yes (initials____) No(initials____)
- 2) Protected health information Yes(initials____) No(initials____)

If your answer is YES to either of the above, please provide us with an acceptable phone number to leave this information (____) _____ - _____

If your answer is NO to either of the above, the staff/ physicians at **natural solutions for women** will, as necessary leave a message indicating your need to call the clinic to retrieve any of your health-related information.

Print Name signature Date

(Office use only): Confidential # _____

Pharmacy: _____