Center for Integrative Medicine and Wellness
7221 Pineville Matthews Road Suite 200
Charlotte, NC 28226

Date _____
Primary Care Physician _____Did this physician refer you?
Yes_____ No_____

If not referred by your doctor, how did you learn about my practice?
_____

PATIENT INFORMATION
Last
Name_____First_____Middle___
E-Mail Address_____
Preferred Name _____Date of Birth
_____

Marital Status: Single (Never Married)_____ Married_____ Separated_____ Divorced_____
Widowed_____

Patient's Social Security Number_____Home Phone_____
Cell Phone_____

Mailing Address
(Number/Street/Unit)_____
_____

City_____State_____ Zip Code_____
Employer_____Your Job Title_____Your Work
Phone_____

PATIENT 'S EMERGENCY CONTACTS
Spouse or Nearest
Relative_____

Relation_____Day Phone_____Evening
Phone_____

Your Supervisor's name if applicable_____His/Her Work
Phone_____
Release of Medical Records Statement to help with Insurance Reimbursement:
I agree to have a copy of my medical records sent to my health insurance company if my insurance company requires such records. (Patients with Medicare insurance do not need to sign.)
Signature of Patient or
Guardian_____Date_____