

CONFIDENTIAL PATIENT INFORMATION

Pearl Integrative Medicine, LLC 620 SE Oak Street, Suite E, Hillsboro, OR 97123
PH: 503.747.3096 FAX: 503.747.3735 www.PearlIntegrativeMedicine.com

NAME: _____ Today's Date: _____ Age: _____

Last First M.I.

DATE OF BIRTH: _____ Gender: Male Female Other Prefer Not to Answer

PHYSICAL ADDRESS: _____
Street City State Zip Code

MAILING ADDRESS: _____
Street City State Zip Code

PHONE #: Home: _____ Mobile: _____ Work: _____

Preferred Contact #: (please circle one) Home Mobile Work

Do you give Pearl Integrative Medicine permission to leave a message with Protected Health Information: YES NO
If yes, please circle what phone number(s) we are able to leave detailed messages on: Home Mobile Work

OCCUPATION: _____ CHILDREN: YES NO How many: _____

Marital Status: Single _____ Married _____ Divorced: _____ Other: _____

Do you live with: Partner/Spouse: _____ Friends: _____ Parents: _____ Alone: _____ Children: _____

INSURANCE INFORMATION

Company name: _____ ID#: _____ Group#: _____

Effective Date: _____ Plan Year: _____ Deductible: _____

PLEASE PROVIDE PRIMARY INSURED'S INFORMATION IF DIFFERENT THAN THE PATIENT

Insured's Name: _____ Date of Birth: _____

Address: _____

Phone #: _____ Relationship to Patient: _____

EMERGENCY CONTACT INFORMATION:

Name Relationship to Patient Telephone #

PHARMACY INFORMATION:

Name: _____ Address: _____

Phone #: _____ Fax #: _____

ALLERGY INFORMATION: _____

What are your most important health concerns? List in order of importance:

1. _____
2. _____
3. _____
4. _____

How did you hear about us? _____