PATIENT INFORMATION SHEET

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name (Last, First, M.I.):	**Male** ☐ **Female** ☐ **Nonbinary** ☐	**DOB** **AGE**

Marital Status:
Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Employment Status:
Full Time ☐ Part-time ☐ Retired ☐ Student ☐ Unemployed ☐

Address:

Home Phone:	**Cell Phone:**
Work Phone:	**Email:**
Emergency Contact Name:	**Emergency Contact Phone:**
Preferred Pharmacy & Address:	**Pharmacy Phone:**

This is where your prescriptions will be sent electronically. It is your responsibility to notify us if your pharmacy has changed.

Who Referred You:	**Current Primary Physician:**

For appointment reminders, which number should we call?
Home Phone ☐ Cell Phone ☐ Work Phone ☐

I agree to get occasional emails on classes, groups, and updates from Dr. Rampil?
Yes ☐ No ☐

Are you involved in an injury/medical lawsuit?
Yes ☐ No ☐

CONSENT TO TREAT

I authorize treatment for myself or my dependents by my signature below. I understand that I am financially responsible to Dr. Laura Rampil, D.O., P.A.

Signature: _____ **Date:** _____

Print Name: _____

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