



Center for Balance and Wellness

Male Patient

Name _____ Birthdate _____

Street Address _____

City _____ State _____ Zip _____

Home phone _____ Cell _____ Work _____

Employer _____ Occupation _____

May we call you at work? **Yes** **No** May we text reminders to you? **Yes** **No**

Email address _____

Marital Status: single married* widowed divorced *Years of marriage _____

Name of Spouse (if married) _____ Birthdate _____

Spouse's Occupation/Employer _____

Spouse's Cell phone _____ Work phone _____

In case of emergency notify (other than spouse) _____

Emergency phone number(s): _____

PRIVACY INFORMATION: Medical information about me can be discussed with or released to:

Name _____ Relationship _____

Name _____ Relationship _____

Signed:: _____ Date: _____