PATIENT INFORMATION

This information will be placed in your confidential medical record and will be used exclusively by **J.C. Tyroler, M.D., LLC and Jay C. Tyroler, MD** to facilitate care.

PLEASE PRINT -- THANK YOU!

____ ______________________________ ______
Last Name **First Name** **M.I.**

____ ____
Address **City, State, Zip**

_____________________ ____
Date of Birth **Name of Spouse/Partner (Full Name)**

__________________________ ______________________________ ____________________________
Home Phone # **Work Phone #** **Cell Phone #**

__________________________ ______________________________ ____________________________
Patient E-mail Address **Pharmacy Name** **Pharmacy Phone #**

Please indicate your preferred contact phone # (circle one): Home Work Cell

May we leave a detailed message at your preferred phone #? Yes No

In addition to yourself, to whom may we release your medical information?

Please list name (s) and their relationship to you: ____

____

_____ I prefer that you address any issues related to my medical care only with me.

Do you check your email on a regular basis? Yes No

Do you use and are you comfortable communicating via text messaging? Yes No

Do you have dependent children signed up for the practice? Yes No

If yes, list name(s): ____

EMERGENCY CONTACT INFORMATION

Please indicate an alternate contact:

________________________________ ________________________ _________________________
Last Name **First Name** **Relationship**

________________________________ ________________________________
Home Phone # **Other Phone #**

_______________________________________/______________________________________/_______________
Name of individual completing this form **Signature** **Date**

Please complete ALL information and return to my office.