Denver Wellness Associates
New Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Okay to leave message? Yes/No Text? Yes/No

Email address (for invoicing): _____

Do you have health insurance? Yes/No If so, what company? _____

(If you have your health insurance card with you, please have the front desk make a copy for your file.)

Preferred Pharmacy: _____

Current Medications:

Name	Dosage	Frequency	Indication

Allergies: _____

_____

Emergency contact:

Name: _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip: _____

Do you give your consent for the above listed emergency contact to be notified in the event of an emergency, not limited to, but including: urgent hospitalization or a medical complication requiring urgent medical attention? Yes / No Initials:_____

Credit card to have on file for payment:

Number: _____ Exp:_____ CCV:_____

-OVER-