Copper Valley Medical
Caring, Compassionate Healing

Patient Information

Patient Name:_____ Date of Birth_____ Age_____Gender ☐M ☐F

Guardian (if minor):_____Relationship: _____

Patient Address: _____
Street Number City State Zip

Contact Information: _____
Home Phone Mobile Phone Preferred: ☐Home ☐Mobile

May we leave a voice message for you on this phone, including medical information? ☐ Yes ☐ No

Email Address:_____May we contact you with information? ☐ Y ☐N

Emergency Contact Information: _____
Name Phone Relationship

Employer: _____
Company Name Address City State Zip

Position title:_____How long: _____

Insurance Provider:_____Group/ID Number: _____

With whom may we leave a message regarding your medical information? _____ No one

Designated Person Only: _____
Name Phone Relationship

May we send you a reminder email, voice mail, or postcard (no medical or personal information)? ☐Yes ☐No

Please tell us how you found out about us:
☐ Web site ☐Patient Brochure ☐ Print Ad(s): _____

☐Referral by physician: _____

☐Referral by patient: _____

☐Other: _____

_____
Signature of Patient Date

For complete records, we need to make a copy of a suitable ID (Driver's License) and Insurance card.