HECKERT HEALTH CENTER, LLC Patient Information Sheet

To	days Date:	//	<u> </u>		
Person completing this form:	□ Self	□ Parent	□ Guardian		
Date of Birth:(mm/dd/yyyy)		Gender: Fe	emale Male		
First Name	MI		Last Name	;	
Street Address					
City	State		Zip Code		
Home Phone		Cell Phone			
Work Phone		Email			
			l 🗆 Mail		
Race: <i>(optional)</i> White			□ Black or Africa Specify	nn American	
Ethnicity: <i>(optional)</i>	lispanic or Latino	□ Declined to	Specify		
□ Employed □ Not Employ	yed 🗆 1	Full-time Student	t 🗆 Part-ti	me Student	
Patient's Employer:					
Employer A	Address		Phone		
Patient Marital Status:	gle	□ Separated	□ Divorced □ \	Widowed	
Spouse's Name (if applicable):					
Emergency Contact Information:					
(#1) Emergency Contact Name		Phone		Relationship	
(#2) Emergency Contact Name		Phone		Relationship	
How did you hear about us?					
What is the reason for your visit tod	av?				

Are there any illness/wellness conditions you would like to work on?				
Preferred Pharmacy:				
Smoking Status: Current every day smoker Former smoker Unknown if ever smoked	 □ Current some day smoker □ Never smoked 			
Medication List: (please list medication na	me, dose, frequency and reason for the medication)			
Allowaioss				
Allergies:				
Duimany Cana Duavidan and/an Spacialist(s)	· ·			
Primary Care Provider and/or Specialist(s)	<u>):</u>			
Past medical history, surgical history, fami	ly history:			
Our Notice of Privacy Practices ("Notice") patients; and 2) how we may use and disclosed Federal regulation requires that we give out before signing this acknowledgment. If you practices, please contact us at Heckert Head (402) 371-0263.	AA Data Use Agreement provides information about: 1) the privacy rights of our pse protected health information about our patients. It patients or their authorized representatives our Notice In have any questions about your rights or our privacy Ith Center, LLC, 109 N. 29 th St, Suite 6, Norfolk, NE 68701. edging that you have been provided access to our Notice.			
Signature of Patient or Authorized Represo	entative Date			
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Print Name of Patient

Print Name of Authorized Representative