PATIENT INFORMATION

Patients Legal Name: Last	First	Middle Initial	Date of Birth / /
Address			
City	State	Zip	
Email	Referring Physician		
Marital Status ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated	Spouses Name		
Social Security No.	Are You: ○ Employed ○ Retired ○ Full-Time Student ○ Part-Time Student		
Primary Phone	Work Phone	Cell Phone	
Birth Sex ○ Male ○ Female	Gender Identity ○ Male ○ Female	Race ○ Caucasion/White ○ African American ○ Native American ○ Other ______ ○ Asian	

PARENT/GUARDIAN INFORMATION

ONLY FILL OUT THIS SECTION IF THE PATIENT IS A MINOR

Parent/ Guardian Name: Last	First	Middle Initial	Date of Birth / /
Address			
City	State	Zip	
Email	Relationship to Patient		
Primary Phone	Work Phone	Cell Phone	

EMERGENCY CONTACT

Name	Phone	Relationship to Patient
Name	Phone	Relationship to Patient

AUTHORIZATION TO RELEASE INFORMATION

If patient is a minor, parents do not need to add themselves to this list, just other individuals.
I hereby authorize confidential communications from the physicians or staff of TPG regarding my health, care, treatments, appointments, prescriptions, etc... to be received by any of the following individuals listed below. I authorize the staff to leave messages on voicemail or with any of the individuals listed below.

Name	Relation	Phone
Name	Relation	Phone
Name	Relation	Phone
Name	Relation	Phone

I understand that this authorization will remain in effect until I revoke the authorization in writing

Patient/Guardian Signature ____________ Date ______