CONFIDENTIAL PATIENT INFORMATION

Pearl Integrative Medicine, LLC 620 SE Oak Street, Suite E, Hillsboro, OR 97123
PH: 503.747.3096 FAX: 503.747.3735 www.PearlIntegrativeMedicine.com

NAME: ______________________________ Today's Date: __________ Age: ________
Last First M.I.
DATE OF BIRTH: ________________ Gender: Male Female Other Prefer Not to Answer
PHYSICAL ADDRESS: ____
Street City State Zip Code
MAILING ADDRESS: ____
Street City State Zip Code
PHONE #: Home: ________________ Mobile: __________________ Work: ______________
Preferred Contact #: (*please circle one*) Home Mobile Work

Do you give Pearl Integrative Medicine permission to leave a message with Protected Health Information: YES NO
If yes, please circle what phone number(s) we are able to leave detailed messages on: Home Mobile Work

OCCUPATION: ______________________ CHILDREN: YES NO How many: ________
Marital Status: Single _____ Married _______ Divorced: ______ Other: _____
Do you live with: Partner/Spouse: ____ Friends: _____ Parents: ____ Alone: ___ Children: ____

INSURANCE INFORMATION

Company name: ________________ ID#: __________________ Group#: ______________
Effective Date: ___________ Plan Year: ____________________ Deductible: ______________

PLEASE PROVIDE PRIMARY INSURED'S INFORMATION IF DIFFERENT THAN THE PATIENT

Insured's Name: _____________________________ Date of Birth: __________________
Address: ____
Phone #: ___________________________ Relationship to Patient: _________________

EMERGENCY CONTACT INFORMATION:

____
Name Relationship to Patient Telephone #

PHARMACY INFORMATION:

Name: ___________________________ Address: ___________________________
Phone #: _________________________ Fax #: ______________________________

ALLERGY INFORMATION: ____

What are your most important health concerns? List in order of importance:

1. ________________________
2. ________________________
3. ________________________
4. ________________________

How did you hear about us? ____