Patient Information Date: ___/____/______

Name:____

I prefer to be called: ____________________________ Date of Birth: ____/____/_______

Address: ____City: _______________________

State: ____________________ Zip Code: __________________

Phone: _________________ Work Phone: _______________ Cell Phone: ______________

Email Address: _____________________________ _Skype Name: ______________________

The best time to contact me is: _____________ ☐ A.M. ☐ P.M.

If a minor, parent or guardian name: ____

Whom may we thank for referring you? ____

Person to contact in case of emergency: ____

Contact's Phone: ____________________________

Name of Primary Health Professional: ____

☐ YES. I give Youngberg Clinic permission to release my medical records, and to communicate via email, post, fax and any recognized form of communication with myself and/or with the below named individual (s)… [Cross out the blanks below if you do not need to share them with others]

1)_______________________ 2)______________________ 3) ______________________

I understand that the Youngberg Clinic is a fee for service provider and is not contracted with any insurance programs.

Patient Signature: ____Date: ____/____/____