

PATIENT INFORMATION

This information will be placed in your confidential medical record and will be used exclusively by **Scott Tong, MD, Inc.** to facilitate care.

PLEASE PRINT -- THANK YOU!

_____	_____	_____
Last Name	First Name	M.I.
_____	_____	
Address	City, State, Zip	
_____	_____	
Date of Birth	Name of Spouse/Partner (Full Name)	
_____	_____	_____
Home Phone #	Work Phone #	Cell Phone #
_____	_____	_____
Patient E-mail Address	Pharmacy Name	Pharmacy Phone #

Please indicate your preferred contact phone # (check one): Home Work Cell
May we leave a detailed message at your preferred phone #? Yes No

In addition to yourself, to whom may we release your medical information?

Please list name (s) and their relationship to you: _____

_____ I prefer that you address any issues related to my medical care only with me.

Do you check your email on a regular basis? Yes No

Do you have dependent children signed up for the practice? Yes No

If yes, list name(s): _____

EMERGENCY CONTACT INFORMATION

Please indicate an alternate contact:

_____	_____	_____
Last Name	First Name	Relationship
_____	_____	
Home Phone #	Other Phone #	

_____/_____/_____ / _____ / _____
Name of individual completing this form Signature Date

Please complete ALL information and return to my office.