WELLNESS FOR LIFE
HEALTHCARE REDEFINED

Patient Information Sheet

First, M, Last Name_____

Street Address/City/Zip_____

Primary Number_____ Mobile / Home / Work (Circle One)

Secondary Number_____ Mobile / Home / Work (Circle One)

Email_____

Social Security Number_____ Date of Birth_____

Preferred Method of Contact (please circle one) Text Message Phone Email

Preferred Pharmacy (Name and Address) _____

Name of Guardian if patient is under 18 years old_____

Emergency Contact (Name/Number/Relationship) _____

Primary Care Provider_____ Specialist(s)_____

Personal Medical History
Known Drug Allergies:
Medication List:
Personal History: **Heart Disease Diabetes Cancer Cholesterol Stroke Seizures Hypertension Lung Disease Genetic Disorder Mental Disorder Blood Disorder Other:**
Immediate Family History:
Social History: **Single Married Divorced Widowed Children Smoking Alcohol**

Insurance Through:

❑ MCCSC	❑ WFL Employee