Confidential Patient Information

Patient Name ____

Age __________ Date of Birth _______________________ Occupation ___________________________

Address____

City__________________________________ State_________________ Zip Code____________________

Cell Phone ___________________________ Work Phone ______________________Extension_________

Home Phone __________________________ E-Mail Address_____________________________________

Marital Status ________________________ Spouse's Name _____________________________________

Name of Emergency Contact_________________ Relationship_____________Phone ______________

Is your condition due to a work injury? Yes / No Have you filed a report? Yes / No

Is your condition due to a car accident? Yes / No Date of Injury/Accident ________________________

Referred by ____

I understand that Dr. Norley and staff *at all times* respect my privacy with respect to all HIPPA regulations.

My well being is the primary concern of Dr. Norley and staff.

There may be times when Dr. Norley or staff will share information regarding my treatment; an example, when consult with another Doctor is to my benefit.

Dr. Norley and staff may contact me by phone, text, mail or e-mail.

Patient's Signature ____ Date ____________________