NEW PATIENT FORM

DATE: _______________

NAME: ____________________________________ DATE OF BIRTH: _______________

ADDRESS: ____

____

EMAIL: ____

TELEPHONE: (Home) ______________________________

(Cell) ______________________________

How did you hear about The Menopause Center? ________________________________

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INSURANCE INFORMATION:____

Pharmacy name: ____

Address: ____

Consent for Treatment:

I hereby authorize the physician to treat me as is appropriate for my medical condition. I understand that Medical Assistants or Registered Nurses may be involved in my care under the direction and supervision of the physician.

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Signature of Patient