



45 Shotwell Road
Clayton, NC 27520

Telephone: (919) 550-5354
Facsimile: (919) 550-5766

Today's Date _____ Chart Number _____

Patient's Name _____
(Last) (First) (Middle) (Maiden)

Patient's Mailing Address _____

City, State & Zip Code _____

Social Security Number _____ Date of Birth _____

Marital Status: M S W D Race _____ Sex: Female Male

Home Number () _____ Work Number () _____

Place of Employment _____
(Name of Company) (Address)

Occupation _____

In case of Emergency Please Notify _____

Telephone Number _____ Relationship _____

Whom were you referred by?

Dr. _____ Friend _____

Relative _____ Advertisement or Yellow Pages

Insurance Information: (Please present card so that we may make a copy for your Chart)

Name of Insurance Company _____

Address to Send Claim _____
(City, State, & Zip Code)

Policy Number _____

Group Name or Number _____

Policy Holder's Name _____

Are you allergic to any medicines? ___ Yes ___ No

If yes, give name of medicine _____