



**Idaho Falls
Clinic, PA**

2001 South Woodruff, Suite 15
Idaho Falls, ID 83404
(208) 522-7310

New Patient Information Questionnaire

TODAY'S DATE _____ MARRIED _____ SINGLE _____ SEX _____

PATIENT'S NAME _____
(FIRST) (MIDDLE) (LAST)

SOCIAL SECURITY # _____ DATE OF BIRTH _____

HOME PHONE # _____ CELL PHONE # _____

MAILING ADDRESS _____
(STREET) (CITY AND STATE) (ZIP CODE)

EMPLOYER _____ WORK PHONE # _____

NAME OF SPOUSE OR RESPONSIBLE PARTY _____

RELATIONSHIP IF NOT SPOUSE _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

SPOUSE EMPLOYER _____ SPOUSE WORK # _____

EMERGENCY CONTACT _____

PHONE # _____ CELL PHONE # _____

PAYMENT DUE AT TIME OF SERVICE