Copper Valley Medical
Caring, Compassionate Healing

Please Note: We Do Not Bill Medical/Health Insurance

Patient Information

Patient Name: _____ Date of Birth_____ Age_____ Gender M F

Guardian (if minor): _____ Relationship: _____

Patient Address: _____
Street Address

_____ _____ _____
City State Zip

Contact Information: _____ _____ _____
Home Phone Mobile Phone Preferred: __ Home __Mobile

May we leave a voice message for you on this phone, including medical information? ____Yes ____No

Email Address: _____ May we contact you with information? __Y__N

Emergency Contact Information: _____ _____ _____
Name Phone Relationship

With whom may we leave a message regarding your medical information? ___ No one

Designated Person Only: _____ _____ _____
Name Phone Relationship

May we send you a reminder email, voice mail, or postcard (no medical or personal information)? ___Yes ___ No

Please tell us how you found out about us:
__Web site __Patient Brochure __Print Ad(s): __Google/Ads __Facebook __Other Social Media

__ Public Presentation __Work or live in the area __Referral by physician: __Referral by patient: _____

__Other: _____

Please list any known drug allergies: __No Drug Allergies

_____ _____ _____

_____ _____ _____

For complete records, we may need to make a copy of a suitable ID (Driver's License).

Signature of Patient

_____ _____
Date

Please complete all pages in this packet

Rev. 11/20