FLORIDA MEDICAL MARIJUANA INSTITUTE

Russell T. Bain, MD, FAAP and Associates

ADULT PERSONAL INFORMATION FORM

PATIENT INFORMATION:

ACCOUNT# _____

CLIENT'S FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SS#: _____ DOB: _____ GENDER: _____MALE _____FEMALE

PHONE NUMBER (PLEASE CIRCLE PREFERRED CONTACT#)

HOME: _____ OFFICE: _____ CELL: _____

CONFIDENTIAL EMAIL (TO SEND YOU CONFIDENTIAL MEDICAL INFORMATION):_____

CONFIDENTIAL FAX (TO SEND YOU CONFIDENTIAL MEDICAL INFORMATION):_____

PERSONAL PHYSICIAN'S NAME: _____ PHONE #: _____

NAME OF EMPLOYER: _____ OCCUPATION: _____

MARITAL STATUS: _____ IF MARRIED/SIGNIFICANT OTHER'S NAME: _____

COPY OF DRIVER'S LICENSE: ❑ YES ❑ NO

SIGNIFICANT OTHER **YOUR RELATIONSHIP TO PATIENT:** _____

FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____

ADDRESS: _____

(IF DIFFERENT FROM ABOVE)

CITY: _____ STATE: _____ ZIP CODE: _____

HOME TELE: (_____) _____ DOB: _____

EMPLOYER: _____ OCCUPATION: _____

WORK #: (_____) _____ EXT: _____ CELL #: (_____) _____

WHOM MAY WE THANK FOR YOUR REFERRAL?

PRINT FULL NAME: _____ **SOURCE:**_____

(i.e. another physician, friend, insurance, yellow pages, etc.)

ARE THEY A PATIENT HERE? ❑ YES ❑ NO

FOR OFFICE USE ONLY

ENTERED IN COMPUTER BY: _____ DATE:_____

(PRINT NAME RECEPT)

FORMS REVIEWED BY: CHECK-IN RECEPTIONIST _____ DATE: _____

(PRINT NAME RECEPT)

Revised 11/30/12