WELLNESS WORKS, LLC
NEW PATIENT INFORMATION FORM

Name: ____ Date: ________________

Date of Birth: ____/_____/_____ Gender: _____________ Race: ________________

Preferred language: ___________ Social Security Number: ____________________

Address: ____

Phone numbers: Preferred: __________________ Other: ______________________

Preferred method of written contact: ____

ALLERGIES
Include drug, food, contrast, latex or other substance

Drug or substance	Reaction

CURRENT MEDICATION
Include supplements, herbals and over the counter medications

Medication	Dosage	Frequency

MEDICAL PROVIDERS
Include Primary Care Provider and Specialists

Name	Specialty	Phone number