

PATIENT INFORMATION

This information will be placed in your confidential medical record and will be used exclusively by the medical practice of **Patrick J. Gallagher, MD** to facilitate care.

PLEASE PRINT -- THANK YOU!

_____	_____	_____
Last Name	First Name	M.I.
_____	_____	
Address	City, State, Zip	
_____	_____	
Date of Birth	Name of Spouse/Partner (Full Name)	
_____	_____	_____
Home Phone #	Work Phone #	Cell Phone #
_____	_____	_____
Patient E-mail address	Pharmacy Name	Pharmacy Phone #

Please indicate your preferred contact phone # (circle one):	Home	Work	Cell
May we leave a detailed message at your preferred phone #?	Yes	No	
May we release your medical information to your spouse/partner?	Yes	No	
Do you check your email on a regular basis?	Yes	No	
May we send health information by email?	Yes	No	
Do you have dependent children signed up for the practice?	Yes	No	

If yes, list names: _____

EMERGENCY CONTACT INFORMATION

Please indicate an alternate contact:

_____	_____	_____
Last Name	First Name	Relationship
_____	_____	
Home Phone #	Other Phone #	

Please complete ALL information and return to Patrick J. Gallagher, MD.