

PRESCOTT CLINIX AND ERBZ RX™

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ADULT/PEDIATRIC DEMOGRAPHIC IDENTIFICATION FORM

A. PATIENT INFORMATION: All information herein contained is Confidential.

Last Name: First: Middle Initial:
Street Address:
City: State: Zip Code:
Soc. Sec. # Gender: Female Male Date of Birth / /
Home Phone: Home Fax:
Cell Phone: E-Mail

Occupation: Self Emphyed Student Retired
Employer: Work Phone: Work Fax:
Street Address:
City: State: Zip Code:

B. Check all that apply: Minor Single Divorced Widowed Married
Spouse: Last: First: Spouse Cell Ph. #:
Spouse Employer: Wk. Ph.: Wk. Fax:
Street Address:
City: State: Zip Code:

If Minor OR You want to Designate your Mother as an Emergency Contact:
Mother's First Name: Last:
Street Address: Same in "A" above Other:
City: State: Zip Code:
Phone: Cell:
Employer: Wk. Ph. Wk Fax:
Street Address:
City: State: Zip Code:

If Minor OR You want to Designate your Father as an Emergency Contact:
Father's First Name: Last:
Street Address: Same in "A" above Other:
City: State: Zip Code:
Phone: Cell:
Employer: Wk. Ph. Wk Fax:
Street Address:
City: State: Zip Code:

Emergency Contact: Relationship to other Emergency Contact: _____
First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone _____ Work Phone: _____ Cell Phone: _____

C. Responsible Party (Name of Person Responsible for this account):

Relationship to patient: Father Mother Other: _____
Date of Birth ___/___/___ Social Security #: _____
Street Address: Same in "A" above **Other:** _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Cell: _____
Employer: _____ Wk. Ph. _____ Wk Fax: _____
Is this person (responsible party) currently a patient of Φ ntegrated Medical Technologies® and Prescott Clinix, erbzRx™ Yes No

D. Other Doctors/Healing Arts Practitioners:

List the names, addresses, phone and fax numbers (if known) of referring physicians, other doctors, chiropractors, psychologists, nutritionists and others helping you with your health care.

<u>Provider Name (MD/DO/DC etc.)</u>	<u>Type of Practice</u>	<u>Address/Phone/Fax</u>
_____	_____	Street: _____ City: _____ St. _____ Zip _____ Phone: _____ Fax: _____
_____	_____	Street: _____ City: _____ St. _____ Zip _____ Phone: _____ Fax: _____
_____	_____	Street: _____ City: _____ St. _____ Zip _____ Phone: _____ Fax: _____

Provider Name (MD/DO/DC etc.)

Type of Practice

Address/Phone/Fax

_____	_____	Street: _____
_____	_____	City: _____ St. _____ Zip _____
_____	_____	Phone: _____
_____	_____	Fax: _____
_____	_____	Street: _____
_____	_____	City: _____ St. _____ Zip _____
_____	_____	Phone: _____
_____	_____	Fax: _____
_____	_____	Street: _____
_____	_____	City: _____ St. _____ Zip _____
_____	_____	Phone: _____
_____	_____	Fax: _____

To the best of my knowledge all of the information stated on this form is true.

Signature of person completing these pages: _____

Date: _____