Patient Information Form

Name of Patient: _____
Date of Birth:_____
Street Address:_____
City:_____ State: _____ Zip:_____
Primary Phone#:(___)_____-_____
*Please indicate if the primary phone# is a….Cell # □ OR Landline # □
Cell Phone#:(___)_____-_____
Work Phone#:(___)_____-_____

Is it ok to leave messages on your:
Primary ph#: YES □ or NO □
Cell ph#, if different than your landline : YES □ or NO □
Work ph#: YES □ or NO □

If patient is a minor…..
Name of Responsible Party:_____
Relationship to Parent:_____

Persons that I give permission for Lebanon Valley Family Medicine to communicate with:

Name:_____ Phone: (___)_____-_____
Relationship to Patient:_____

Name:_____ Phone: (___)_____-_____
Relationship to Patient:_____

Name:_____ Phone: (___)_____-_____
Relationship to Patient:_____