Robin Dale MD
Family Medicine

Patient Information Sheet

Name _____ Social Sec # _____
Last First MI

Sex _____ Birthdate _____ Aliases _____

Address _____ Home phone # _____
City _____ Work phone # _____
State _____ Zip _____ Mobile phone # _____
Parish _____ Email _____

General Info

Needs interpreter? Yes or No Preferred language _____
Marital Status _____ Religion _____
Ethnicity _____ Race _____

Appointment Reminder Preferences ___phone text email _____
Primary Care Physician Dr Dale or other _____

Patient Contacts

Name _____ Relationship _____
Last First MI
Phone Number _____
Home Work Mobile

Guarantor Info (if different from patient, ie, the person responsible for the bill)

Name _____
Last First MI
Address _____ Social Security #_____
City _____ Sex _____ Birthdate _____
State _____ Zip _____ Home phone # _____
Parish _____ Work phone # _____
Fax # _____
Employer _____ Employment Status _____

Do you have an Advance Directive? Yes No If yes, please provide a copy to us ASAP.
If no, do you want information on an Advance Directive? Yes No
I have received the Notice of Privacy Practices form. _____ Date _____
(The complete form is also on the website at www.RobinDaleMD.com) Signature of patient or guardian