BETHESDA HEALTH

Last Name: ______________First Name: ____________Middle: _____Preferred Name___________

Preferred Pharmacy: ____

____

DOB: ___________________ Male: ____Female: _____ SSN: _____________________

Race: __________Ethnicity: ___________ Primary Language: ____________Marital Status: ______

Address: ____

Zip: ______________________ City: ______________________ State: ________________________

Phone: Home: ____________Work: _____________ Cell: ____________Primary:_______________

Preferred Communications: Phone-Home ___________________Phone-Cell _____________________

Out-of-town address: ____

____

Emergency Contact: _______________________________ Phone number: ____________________

Relationship: ______________________________ Date of Birth _______________________

Financially Responsible Party: ________________Relationship: ___________ DOB: _____________

How did you find us: ____

Do you have a living will or DNR form: _______ If yes, need a copy on file. (If not, we encourage you to do so; ask us for five wishes.)

Person authorized to make medical decision on your behalf including, but not limited to, Life-Prolonging procedures in the event you are medically incapable (Power of Attorney):

Name: ____

Address: ____

Phone: ____

2465 State Road 7, Suite 800, Wellington, FL 33414 • Phone: 561-793-4489 Fax: 561-793-1425