



SUNRISE
FUNCTIONAL MEDICINE

Contact Information (PLEASE PRINT CLEARLY)

Patient's Full Name: _____

Date of Birth: _____

Home address _____

City _____ State _____ Zip _____

Primary phone: Daytime () _____ Evening () _____

Cell phone () _____

Name of responsible party (if different than patient): _____

Relationship to patient: _____

Which number do you prefer we contact you at? ____ Work ____ Home ____ Cell

Email address (where we should send all correspondence):

Insurance Provider _____

Do you wish to have a diagnostic code receipt to seek insurance reimbursement?

Yes _____ No _____

What name do you prefer to be called? _____

Who referred you to our office? _____

Emergency contact:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home phone () _____ Work or cell phone () _____

For children under 18 years of age:

Father's full name _____

Mother's full name _____

School attending _____ City _____