

Laser Wellness of Alabama Family Practice, P.C.  
370 St. Lukes Drive  
Montgomery, AL 36117

## Patient Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
                    First  Middle  Last

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Driver License Number: \_\_\_\_\_

Marital Status:      Single Married      Other

Home # \_\_\_\_\_ Fax # \_\_\_\_\_

Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Is it permissible to leave a message at these numbers? **Please circle all numbers we can leave you a message.**

E-Mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact Name & Number: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

What is your main reason for visiting our office today? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(If under the age of 14)