WellnorthMedical
INTERNAL AND WELLNESS MEDICINE
1630 Mineral Springs Ave, Ste 2, North Providence, RI 02904
Phone: 401-438-1010 Fax 401-354-4760

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ ZIP: _____

Social Security #: _____/_____/_____ Date of Birth: _____/____/_____ Sex: M / F Age: _____

Home Phone #: (_____) _____–_____ Cell Phone # (_____) _____– _____

Marital Status: _____ Spouse Name: _____

Employer: _____ Work Phone: (_____) _____–_____

If under 18, Parent or Guardian: _____

Referred by: _____

In case of Emergency, contact: _____ Work Phone: (_____) _____–

Email Address_____@_____ (For access to Our New Patient Portal)

Race:
____ American Indian or Alaska native ____ Black or African American ____ Other Race
____ Asian ____ White ____ Refused to report
____ Native Hawaiian/Pacific islander ____ Hispanic

Ethnicity: _____ Hispanic or Latin _____ Non Hispanic _____ Refused to report

Language: _____ English _____ Spanish _____ French _____ Japanese _____ Chinese ___Other_____

Pharmacy Name: _____ **Street and City**:_____

I wish to be contacted in the following manner (check all that apply)

_____ Home Telephone: _____

_____ O.K. to leave message with detailed information (Extended)

_____ Leave message with call-back number only (Brief)

_____ Cell Phone: _____

_____ O.K. to leave message with detailed information (Extended)

_____ Leave message with call-back number only (Brief)

_____ Work Telephone:

_____ O.K. to leave message with detailed information (Extended)

_____ Leave message with call-back number only (Brief)

HIPPA:
Please list any individual(s) you would like for your personal healthcare information to be disclosed. **NOTE:** If you do not list anyone, we may ONLY release information to you.

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