THE COLE CENTER FOR HEALING

NAME:	EMPLOYER;
DATE OF BIRTH:	EMPLOYER ADDRESS:
HOME ADDRESS:	EMPLOYER PHONE#
CITY: STATE: ZIP:	SSN:
PHONE #1	PHONE #2
EMAIL:	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED
RACE: ☐ WHITE ☐ BLACK ☐ HISPANIC/LATINO ☐ ASIAN ☐ DECLINED	
ETHNICITY: ☐ NOT HISPANIC/LATINO ☐ HISPANIC/LATINO	DOMINANT HAND: LANGUAGE:

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME:	RELATIONSHIP TO PATIENT:
ADDRESS: ☐ SAME AS ABOVE	DATE OF BIRTH:
CITY: STATE: ZIP:	SSN:
PHONE #1	PHONE #2

Emergency Contact (EC)/ Release of Information (ROI). Please check the boxes that apply.
Name of person to contact in case of emergency/ or we may release information to:
*Please make sure to check mark the boxes that apply

NAME	PHONE#	RELATIONSHIP	EC/ROI
			☐ EC ☐ ROI
			☐ EC ☐ ROI
			☐ EC ☐ ROI

Print:____________________________ Sign:____________________________ Date:_______________

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Patient Name:____

I,_________________________, give my permission to have detailed messages regarding all tests including but not limited to blood work, comprehensive stool analysis, hair analysis, etc., left on the secure phone line and/or e-mail provided. If the patient is a minor or you are the legal guardian please print your name and relationship to the patient,__________________________.

____

Patient Signature

I acknowledge by typing my name above it is the same as my signature.

PHARMACY INFORMATION

Pharmacy Name____

Address____

Pharmacy Number____

HIPPA POLICY

I, the undersigned, hear by attest that I have received and read a copy of the current HIPPA agreement. I acknowledge by signing below that I have no questions regarding the policy and release the Cole Center from any liability regarding HIPPA. I acknowledge by typing my name below it is the same as my signature.

____

Patient Name

DISCLAIMER

Patients of the Cole Center are not required to purchase recommended supplements through DrVitamins. All supplements are available for purchase from other distributing nutraceutical stores. I understand that Dr. Cole will continue to treat me to the best of his skill and ability without regard for where I choose to purchase my vitamins and supplements. Please note there is a familial relationship between the Cole Center and the proprietorship of DrVitamins, LLC.

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I acknowledge by typing my name above it is the same as my signature.