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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