OPTIMAL WELLNESS
CLIENT INFORMATION SHEET

Today's Date: ___________________________

Name (printed): Last________________________ First _________________ MI _____

Street Address: ____

City, State, Zip Code: ____

Home phone: (_____) _____-__________

Work/Cell (circle one): (_____) _____-_________

Date of birth: _____/_____/________

month day year

Email address: ____

Emergency Contact Name: ____

Emergency Contact Phone number: _________________________________

Primary Care Physician: ____

Primary Care Physician Phone Number: ______________________________

Copies of today's visit sent to your Primary Care Physician: ___ yes ___ no

Referred by: (please check)

____ Current client ____________________________(name)

____ Health care provider _______________________(name)

____ Other ____

_____ I acknowledge that I have received a copy of the Optimal Wellness Office Policies
(initial)

_____ I have received a copy of the Optimal Wellness Cancellation Policy
(initial)

Please visit our website at owforlife.com to sign up for Dr. Ruby's newsletter and blogs.