Carol Park
L.P.C., R.D., L.D., CEDRD
1702 North Collins Blvd, Suite 207
Richardson, TX 75080
469.324.9744 | carolparklpc@gmail.com

Please complete the information and answer the questions below. Note that the information you provide to me here is protected as confidential patient information.

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street and Number City State Zip Code

(if minor, please complete)
NAME OF PARENT/GUARDIAN: _____
Last First

CONTACT INFORMATION:

HOME PHONE: (____) - ____ - ____ *May I leave a message?* ☐ *yes* ☐ *no*

CELL PHONE: (____) - ____ - ____ *May I leave a message?* ☐ *yes* ☐ *no*

WORK PHONE: (____) - ____ - ____ *May I leave a message?* ☐ *yes* ☐ *no*

E-MAIL ADDRESS: _____
Please note that email correspondence is not considered to be a confidential means of communication.

DATE OF BIRTH: ____/____/____ **AGE:** _____ **GENDER:** ☐ Female ☐ Male

MARITAL STATUS:
☐ Never Married ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

PLEASE LIST ANY CHILDREN AND THEIR AGE (S):

_____

OTHER HEALTH/SERVICE PROVIDERS *(e.g. Primary Care Physician, Psychiatrist, etc.)*:

NAME: _____ PROVIDER ROLE: _____
ADDRESS: _____ PHONE: _____

NAME: _____ PROVIDER ROLE: _____
ADDRESS: _____ PHONE: _____

EMERGENCY CONTACT (S):

NAME: _____ RELATIONSHIP to PATIENT: _____

ADDRESS: _____ PHONE: _____

REFERRED BY: _____ **PHONE:** _____