CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

3201 Hallmark Court
Saginaw, MI 48603
Phone: 989-790-5990
Fax: 989-790-5991

PATIENT DATA SHEET

☐ Initial ☐ Update

Name: | Account:

PATIENT INFORMATION

Full Name: _____
Last First Middle Initial Suffix
Street Address: _____
City / State / Zip: _____
Phone Numbers: Cell:_____ Home :_____Work: _____
E-Mail Address: _____
DOB: _____Age: _____ Gender: ☐ M ☐ F Race_____
Marital Status: _____Employment Status: _____Education: _____
Source of Referral: _____

EMERGENCY CONTACT INFORMATION

Name: _____Relationship: _____

Address: _____Phone: _____

CONFIDENTIAL COMMUNICATION INFORMATION

Do you have concerns with our office telephoning you at home or sending mail to your home?
☐ Yes ☐ No Patient Comments: _____
ONLY if the answer is YES, complete the information below:
1. May postcards/letters, which identify our facility (CMU Health Behavioral Medicine) be sent to this address: ☐ Yes ☐ No
2. What is the address for written confidential communication, if different than the address listed above? _____
3. Is there an alternative phone number to be used for communication? ☐ Yes ☐ No
4. If YES to #3, what is the alternative telephone number? _____
5. If YES to #3, what time(s) may we call? _____
6. May our staff/facility leave a message at this phone number? ☐ Yes ☐ No
7. May this message include the name of our facility/staff? ☐ Yes ☐ No
8. May we leave a blind message with our phone number only? ☐ Yes ☐ No

PERSONAL/LEGAL REPRESENTATIVE INFORMATION (IF APPLICABLE)

Representative Name: _____ Relationship: _____
Address: _____Phone: _____
Do you have proof of power of attorney / guardianship with you? ☐ Yes ☐ No

Patient Signature: | Date:

**Note: When a patient indicates that changes have occurred since his/her last appointment, then reassess the patient's preference for confidential communication.*