

REIU PATIENT UPDATE PROFILE SHEET

DATE: _____

PATIENT INFORMATION	PARTNER'S INFORMATION
NAME: _____	NAME: _____
ADDRESS: _____ _____	ADDRESS: _____ _____
DATE OF BIRTH: ____/____/____	DATE OF BIRTH: ____/____/____
SS#: _____	SS#: _____
HOME #: () _____ IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOME #: () _____ IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
WORK #: () _____ MAY WE CONTACT YOU AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WORK #: () _____ MAY WE CONTACT YOU AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
MOBILE # () _____ IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	MOBILE # () _____ IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER: _____	EMPLOYER: _____
MEDICAL INSURANCE: _____ POLICY #: _____	MEDICAL INSURANCE: _____ POLICY #: _____
ALLERGIES: _____ BLOOD TYPE: _____	ALLERGIES: _____ BLOOD TYPE: _____
PHARMACY INSURANCE: _____ POLICY #: _____ PHARMACY NAME: _____ PHARMACY TELEPHONE #: () _____	PHARMACY INSURANCE: _____ POLICY #: _____ PHARMACY NAME: _____ PHARMACY TELEPHONE #: () _____
<u>PLEASE ANSWER & SIGN:</u> MAY WE DISCUSS YOUR TEST RESULTS WITH YOUR PARTNER/SPOUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO SIGNATURE:	<u>PLEASE ANSWER & SIGN:</u> MAY WE DISCUSS YOUR TEST RESULTS WITH YOUR PARTNER/SPOUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO SIGNATURE:
PREFERRED SMH LAB LOCATION: _____	
REFERRING PHYSICIAN/OB/GYN: _____ DATE LAST SEEN: _____	
Would you like to receive our newsletter <i>electronically</i> _____ or <i>by mail</i> _____ ? E-MAIL ADDRESS: _____	

