Sage Mountain Health, LLC

1341 Harrion ave. Butte MT 59701 406 299-2944

NEW PATIENT INFORMATION

Name_____

Preferred Name_____

Date of Birth: _____ Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone Number: _____ ok to leave a message Y or N

Personal Email: _____ok to email appt reminder or info Y or N

Children: Yes or No

Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone Number: _____ Address: _____

DISCRIBE THE REASON FOR YOU VISIT

_____

_____

_____

_____

CURRENT THERAPIST OR PHYSICIAN

Physician Name: _____

Phone: _____ Fax: _____

PAST MEDICAL HISTORY

Current Medical Problems: _____

Previous Substance Treatment: _____`

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING: _____

_____

LIST YOUR PHARMACY NAME AND PHONE NUMBER:_____

_____

MAIL ORDER PHARMACY NAME AND PHONE NUMBER:_____

_____

PLEASE LIST ANYONE THAT WE MAY SPEAK WITH REGARDING YOUR CARE (EX: SPOUSE/PARENT/PHYSCIAN). IF NO NAME IS LISTED WE WILL NOT BE ABLE TO RELEASE INFORMATION TO ANYONE THAT CALLS ON YOUR BEHALF. _____

_____

SIGNATURE: _____ DATE: _____