Dr. Kellyn Milani
602 S. Ferguson Ave, Suite 4
Bozeman, MT 59718
406-624-6284
406-548-9755
www.RemedyNaturalHealth.com

1. Demographic Information.

First Name: _____ Middle Name: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Primary Language _____

Address: _____ Apt./Unit #: _____

Mobile Phone: _____
May we contact you at this number?
☐ Yes ☐ No
May we leave messages for you at this number?
☐ Yes ☐ No

Home Phone: _____
May we contact you at this number?
☐ Yes ☐ No
May we leave messages for you at this number?
☐ Yes ☐ No

Work Phone: _____
May we contact you at this number?
☐ Yes ☐ No
May we leave messages for you at this number?
☐ Yes ☐ No

May we send you text messages including appointment reminders?
☐ Yes ☐ No

(If you opt in to receive text messages, we will send you text message appointment reminders when you have an upcoming scheduled appointment at Remedy Health. You can choose to opt out at any time by contacting our office at 406-624-6824. Agreement to receive a text message is not a condition of purchasing a good or services. Message and data rates may apply.)

Email: _____

May we contact you at this email, including appointment reminders?
☐ Yes ☐ No

Preferred contact method:
○ Mobile Phone ○ Elation Passport Message ○ Work Phone ○ Home Phone

Would you like to be added to our email newsletter?
☐ Yes ☐ No

Emergency Contact _____ Emergency Contact Relationship _____

Emergency Contact Phone

2. **Please list your preferred pharmacy information below:**

	Name	Address	Phone #	Fax #
Preferred Pharmacy				

3. **Insurance Information.**

While we do not process insurance at our clinic, we have found it helpful to have this information on file for your convenience.

Insurance Name

Insurance Phone#

Member's Name

Member's DOB (if not the patient)

Member ID#

Group #

4. **You can upload a copy of your insurance card here.**

5. **Allergies**

Do you have any known drug allergies?
☐ Yes ☐ No

If yes, please list your drug allergies:

Do you have any food allergies?
☐ Yes ☐ No

If yes, please list your food allergies:

6. **List any prescribed medications you are currently taking:**

	Name	Dosage	How long?
1			
2			
3			
4			

7. List any supplements or over-the-counter medications you are currently taking:

	Name of supplement	Dosage	How long?
1			
2			
3			
4			

8. Is there anything else you would like me to know?