Juandalyn Peters, M.D.
4801 South University Drive, Suite 204
Davie, FL 33328

Patient Information Form

Patient Name ____________________________________ Date __________________

Names of Parent(s)/Guardian(s) ____

Who referred you to this office? ____

Address: ____

Home Phone _______________ Cell Phone _____________ Work Phone ___________

Which phone number may we use to contact you to confirm appointments? _________

Email Address: ____
By providing my email address, I consent to the use of this form of communication.

I consent to receive text messages, understanding that this is not a secure form of communication. Please circle one: Yes No

Date of Birth ____________ Age ______ Sex _______

School/Employer (if applicable) _________________________ Grade ______________

Name of Preferred Pharmacy ___________________________ Phone ______________

Allergies ____

Current medications (include times and dosages of all prescription and non-prescription medications, for example herbs and pain killers taken regularly)
____
____
____

Name of person financially responsible, if other than patient, parent/guardian above:

____ Relationship _______________

Address ____

Social Security Number ________________ Date of Birth of Insured _______________

Note: This office does not accept insurance assignment as payment.

____ ____________
Signature of Adult Patient/ Parent or Guardian of Minor Patient Date