3615 West Charleston Blvd., Las Vegas, NV 89102 Phone: 702-508-9461 www.cairncenter.com

Patient Information Form

First Name: ___________________________**Last Name:** ___________________________**MI:** ____

DOB: ___________________________ **Age:** ____________ **Sex:** Male or Female (circle one)

Home #: _____________________________________ **Cell #:** ________________________________

I **do/do not (please circle)** authorize the Cairn Center to leave messages at these numbers.

Address: ____

Street City State ZIP Code

Marital Status: ________________

Employer: ____________________________________ **Occupation:** __________________________

Emergency Contact: ___________________________________ **Phone:** _______________________

I understand that The Cairn Center may call my emergency contact in the case of emergency (medical or mental) and I give them permission to do so. I also agree to update my phone number and address immediately if changes occur.

Patient Signature: ____