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PATIENT INFORMATION		Today's Date: _____
Last Name:	First Name:	Middle:
SS#:	Birth date:	Dirver Lic #
Mailing Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	e-mail:
EMPLOYER		
Name:		Position:
Address:		
City:	State:	Zip:
Work Phone:		Fax:
How may we contact you? (check all that apply) <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> e-mail		

INFORMATION <input type="checkbox"/> SPOUSE or <input type="checkbox"/> PARENT (IF MINOR)		
Last Name:	First Name:	Middle:
SS#:	Birth date:	
Mailing Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
EMPLOYER		
Name:		Position:
Address:		
City:	State:	Zip:
Phone:		Fax:

NEAREST RELATIVE NOT LIVING WITH YOU		
Last Name:	First Name	Middle:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	

INSURANCE INFORMATION: Please give your insurance card(s) to the Receptionist to photocopy