Essential Family Medicine, LLC.
Lori Dunnavant, FNP-C

First Name: ____________________ Middle:_________________ Last: _______________________

Preferred Name:______________________ DOB:________________ Reminders: Call Text Email

Address: _____________________________________ City: _____________________ Zip: ___________

Phone Home: _____________________ Cell:______________________ Work: ____________________

Email: _____________________________ SS#: _________________________ *Male Female*

Emergency Contact Name: _____________________ Phone:_________________ Relationship:_______

Primary Insurance: _____________________________ Who is the policy holder: *Self Spouse Parent*

Policy holder DOB: ______________ Policy Holder Name & Employer : ___________________________

Policy holder SS#:_________________________Secondary Insurance: ___________________________

** HIPAA Policies are available upon request.
** If 24 hour cancellation notice is not provided, you will be subject to a $20 fee.
** I understand it is my responsibility to provide any additional information such as: living wills, medical records, do not resuscitate (DNR) orders and etc.
** Due to liability, no illnesses or injuries will be treated over the telephone, A face to face visit must be made.
**No narcotic or scheduled drug prescriptions will be given on a regular basis except under certain circumstances that are at the provider's discretion. If the need arises for long term chronic pain management, you will be referred to a pain clinic.

Signature ____ **Date** _________