

The Senator William and Ellen Proxmire Memory Clinic  
At Copper Ridge

PATIENT and FAMILY CONTACT INFORMATION

**Patient Name (please print):**

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First Middle Last

Married

Widowed

Divorced

Single

**Contact information to schedule/change/confirm appointments:**

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First and Last Name Relationship to Patient

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Address: Street, City, State, Zipcode

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Cell Phone Number Home Phone Number

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Email Address

**Preferred method of contact:**     Cell phone number     Home number     Email

**If applicable, does a member of the patient's family have Medical Power of Attorney?**

Yes

No

*If yes, please provide a copy of the Medical Power of Attorney at the first appointment.*