

Patient Information

NAME: _____ AGE: _____ DATE OF BIRTH: ____ / ____ / ____
ADDRESS: _____ PHONE: (____) _____
CITY: _____ STATE: _____ ZIP: _____ SS#: _____
MARRIED: YES ___ NO ___ NUMBER OF CHILDREN (if applicable): _____
EMPLOYER: _____
EMPLOYER ADDRESS: _____ STATE: _____ ZIP: _____
OCCUPATION: _____ OFFICE PHONE: _____
SPOUSE'S NAME: _____ BIRTH DATE: ____ / ____ / ____ SS#: _____
IN CASE OF EMERGENCY, NOTIFY (other than spouse): _____
ADDRESS: _____ STATE: _____ ZIP: _____
PHONE: _____ RELATIONSHIP: _____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: _____
WHAT BROUGHT YOU TO OUR OFFICE: _____
NAME OF MEDICAL DOCTOR: _____ PHONE: _____
ADDRESS: _____ STATE: _____ ZIP: _____

The following points are important that you read and agree to in order for you to become a patient at our clinic.

- All services rendered will be considered cash until your insurance is verified.
- If you are unable to keep your appointment, we require that you call ahead to cancel so that someone else, if needed, can be put in your appointed time.
- Payment for services rendered that day are due before you leave unless other financial arrangements have been made.

By signing this, I acknowledge that I have read and agree to the above office policies.

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature: _____ Date: _____