

Date: \_\_\_\_\_

Whom may we thank for referring you?  
\_\_\_\_\_

**Patient Information**

Child  Single  Married  Divorced  Widowed

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State & Zip

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Birthday: \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_  
Company Name Address City, State & Zip

Full Time Student?  Yes  No If Yes, \_\_\_\_\_  
School Name Location Grade

Spouse's Name: (Parent Information if a minor) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State & Zip

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Birthday: \_\_\_\_\_ SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_  
Company Name Address City, State & Zip

**Emergency Contact Information**

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest friend not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

**Account Information**

Person responsible for Account:  Self  Spouse  Parent

- Payment is due at the time of service.
- A missed appointment fee of \$25.00 per hour will be charged for all appointments missed or cancelled without 24 hour prior notice.

professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true to the best of my knowledge. I will notify you of any changes to the above information.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any

X \_\_\_\_\_  
Responsible Party's Signature Date