

Patient Information Form

Name _____ Home phone _____ Cell phone _____

Work phone _____ E-mail address _____

Home address _____ City _____ Zip _____

Spouse's name _____ Work Phone _____

Nearest relative not living with you _____ Phone _____

Nearest friend not living with you _____ Phone _____

Physician _____ Phone _____

Dentist _____ Phone _____

Landlord _____ Phone _____

Whom may we contact in the case of an emergency?

_____ Phone _____

Whom may we thank for referring you to us?

_____ Phone _____

Social Security Number _____ Date of birth _____

Who is responsible for this bill? _____

I will be paying today by cash _____ check _____ credit card _____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature

Date

Parent (if minor)

Date