PATIENT INFORMATION

PATIENT NAME _____
Last Middle Initial First

STREET ADDRESS _____ APT# _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SEX _____ MARITAL STATUS _____

Please check preferred contact method: **Providing Cellphone number will automatically OPT you in to Appt. Confirmations. Please indicate if you want do NOT wish to OPT in.**

CELL ◯ _____ WORK ◯ _____ HOME ◯ _____

E-MAIL ◯ _____

May we contact you via text and/or e-mail for appointment reminders, specials and promos? Yes ◯ No ◯

EMPLOYER _____ OCCUPATION _____

EMPLOYERS ADDRESS _____

SPOUSES NAME _____ SPOUSES OCCUPATION _____

EMPLOYER _____ EMPLOYER'S PHONE # _____

EMPLOYER'S ADDRESS _____

_____

EMERGENCY CONTACT NAME **RELATIONSHIP** **PHONE**

RESPONSIBILITY PARTY

Please complete the following if someone other than the patient is responsible for payment of services.

NAME OF RESPONSIBLE PARTY _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

HOME PHONE _____ BUSINESS PHONE _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____

I have completed this form fully and certify that I am the patient or legal agent of the patient authorized to furnish the information requested.

_____

SIGNATURE OF PATIENT, PARENT, OR RESPONSIBLE PARTY DATE