

PATIENT'S NAME _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

EMAIL _____ CELL PHONE _____

PATIENT'S SOCIAL SECURITY NUMBER _____ PATIENT'S DRIVER'S LICENSE NUMBER _____

PREFERRED NAME(NICKNAME) _____ BIRTHDATE _____

MARITAL STATUS _____ OCCUPATION _____

IF PATIENT IS A STUDENT OVER AGE 19, SCHOOL NAME _____

RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

IF DIFFERENT FROM ABOVE ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

SOCIAL SECURITY _____ BIRTH DATE _____

HOW WERE YOU REFERRED TO THIS OFFICE? _____

ADDRESS AND PHONE NO. OF REFERRAL _____

PLEASE READ CAREFULLY AND SIGN BELOW

- A. Please be prepared to pay for services as they are performed. Accounts 60 days Past Due are subject to a 1 1/2% Late Payment Charge.
- B. Financial arrangements (including insurance forms) will be prepared prior to treatment in order to adequately establish responsibility.

C. REGARDLESS OF INSURANCE COVERAGE, YOU WILL RECEIVE A STATEMENT FROM THIS OFFICE. The responsibility to follow up insurance claims in yours. If there is a delay in giving us the information or receiving payment from the insurance company, we expect payment in full from the patient.

PATIENT'S NAME _____ DATE _____