PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date_____ Patient Name _____

❑ Male ❑ Female Birthdate_____ Home phone _____

Address_____ City_____ State/Prov._____ Zip/P.C. _____

E-Mail_____ Cell phone _____

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Occupation _____

Patient's or parent/spouse's employer_____ Work phone _____

Address_____ City_____ State/Prov._____ Zip/P.C. _____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone _____

Responsible Party

Name of person responsible for this account_____ Relationship to patient_____

Address_____ Birthdate _____

Home phone_____ Cell phone _____

Employer_____ Work phone _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and treating.

X _____ _____

Signature of patient or parent/guardian if minor — Date

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