PATIENT INFORMATION

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

Date_____ Patient Name_____

☐Female ☐Male ☐Unspecified / ☐ Married ☐Single Birthdate_____

Address_____City_____State_____Zip/P.C._____

E-Mail_____ Cell Phone _____

Occupation_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____Phone_____

Relationship to patient_____

Responsible Party (if other than patient)

Name _____ Relationship to patient_____

Address_____Birthdate_____

Cell Phone_____ Email _____

Payments

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

Payment is due at the time services are rendered. A processing fee applies to debit and credit card payment transactions. The fee is waived when paying by cash or cashier's check. _____ (initial)

Surgery payments are due 3 weeks in advance of surgery.

X_____ _____

Signature of patient or parent/guardian if minor Date