PLEASE PRINT

Date of appointment: _____

Name: _____ Birth date: _____
First Middle Last

Address: _____
Please No P.O. Boxes

_____ Age: _____ Sex: ___ F___M
City State Zip

Are you Hispanic? Yes No Preferred language: _____ Race: _____

E-MAIL ADDRESS: _____
By providing your e-mail address you are allowing our office to use this as a form of communication (i.e.: correspondence, communication, or newsletters)

Home Phone _____ Cell Phone _____

Social Security Number _____

Employer _____ Work Phone _____

Who is your primary treating physician? _____

Were you referred to us? _____ If Yes, by who? _____

MARITAL STATUS (Please circle one) Single Married Divorced Separated

IF THE INSURANCE INFORMATION IS NOT IN YOUR NAME, WE MUST HAVE THE FOLLOWING

Whose name is the insurance under? _____

Their address: _____

Their social security number: _____

Their date of birth: _____ Sex: M___ F___

What is your relationship to this person? _____

By signing this consent to treat you are also giving us permission to leave messages on your answering machine/voice mail.

Patient consent for treatment _____

Guardian consent for treatment_____

In Case of Emergency, notify: _____ Phone _____

Name of nearest relative not living with you _____

Phone: _____ Address: _____

Fees at this office will be paid by: _____

PATIENT'S SIGNATURE

I will be paying today by ____ Cash _____ Check _____ Credit Card