

Client Information

Name: _____ DOB: _____ Sex: ___ Male ___ Female

Street: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ SS#: _____

Home Phone: _____ May we call you at home? ___ At work? ___

Work Phone: _____ Employer: _____

Cell Phone: _____ Email: _____

**Medical Information*

Physician's Name: _____ Date of last physical exam: _____

Are you on any regularly prescribed medications? ___ If so, please list them:

**By whom were you referred to this practice?* _____

**Spouse/Parent Information*

Name: _____ DOB: _____ Sex: ___ Male ___ Female

Street: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ SS#: _____

Home Phone: _____ May we call you at home? ___ At work? ___

Work Phone: _____ Employer: _____

Cell Phone: _____ Email: _____

**Others living in your household:* _____ DOB: _____

_____ DOB: _____

**To whom shall we mail your monthly statement? Please note that we will bill charges to your insurance carrier if you desire. However, a statement will be mailed to you each month as well. You are responsible for payment of all charges until your insurance company pays.*

Responsible Party: _____ Relationship to Client: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ SS#: _____

Employer: _____

**In case of an emergency, please contact:*

Name: _____ Phone: _____

Relationship to Client: _____