PATIENT INFORMATION (CONFIDENTIAL) **DATE** _____

NAME _____
FIRST **MI** **LAST**

ADDRESS: _____**CITY**_____**STATE**_____**ZIP**_____

PHONE-DAY:_____**CELL:**_____**EVENING:**_____

DATE OF BIRTH: _____**SOCIAL SECURITY #:**_____

DRIVER'S LICENSE #: _____**E-MAIL ADDRESS:** _____

EMPLOYER: PATIENT'S/PARENT'S_____**PHONE:**_____

EMPLOYER'S ADDRESS _____**CITY**_____**STATE**_____**ZIP**_____

SPOUSE/PARENT NAME: _____

EMPLOYER: _____ **PHONE:**_____

CHILDREN: NAME_____**AGE**_____**NAME**_____**AGE**_____

NAME_____**AGE**_____**NAME**_____**AGE**_____

IN EMERGENCY PLEASE CONTACT: _____**PHONE:**_____

ADDRESS: _____**CITY**_____**STATE**_____**ZIP**_____

PERSON RESPONSIBLE FOR ACCOUNT: _____**PHONE:**_____

ADDRESS: _____**CITY**_____**STATE**_____**ZIP**_____

PHONE: DAY_____**EVENING**_____

EMPLOYER: _____**PHONE:**_____

INSURANCE INFORMATION:

NAME OF INSURED: _____**DATE OF BIRTH:**_____**SS#:**_____

EMPLOYER NAME & ADDRESS:_____

INSURANCE CO:_____**GROUP #:**_____

WHOM MAY WE THANK FOR REFERRING YOU_____

A service charge of 1.5% per month may be added to all accounts not paid in full within 60 days of completion of treatment or account due date. I understand if payment is not made when due the account may be turned over to collection. I will be responsible for any & all costs associated with the collection procedure, including but not limited to billing costs, collection fees, and court costs

PATIENT OR PARENT'S SIGNATURE_____