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 OR PARENT'S_____ PHONE:_____

EMPLOYER'S ADDRESS_____CITY_____STATE_____ZIP_____

SPOUSE OR 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_____

EMPLOYER: _____PHONE:_____

INSURANCE INFORMATION:

NAME OF INSURED: _____ DATE OF BIRTH:_____SS#_____

EMPLOYER:_____POLICY#_____GROUP#_____

INSURANCE CO:_____PHONE#:_____

PATIENT OR PARENT'S SIGNATURE_____

The following information is provided to avoid any confusion regarding our cancellation policy and to best serve all of our patients. If you must cancel, please notify us withing 24-48 hours via phone. We ask that you speak directly to a person. Failure to notify our office at least 24 hours in advance will result in a cancellation fee of $50.00

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