WELCOME TO OUR PRACTICE

Please share the following information with us:

Patient's Name: ____________________

Spouse's Name: ____________________

Patient's Address: ____________________city/zip____________________

Home Phone #: (   )____________________ Work Phone #: (   )____________________

Cell # (   )____________________

Date of Birth: ____________________ Social Security #: ____________________

Driver's License #: ____________________ State of License: ____________________

Employer: ____________________ Present Position: ____________________

Business Address: ____________________

Whom may we thank for referring you: ____________________

FAMILY ACCOUNT INFORMATION

Person Responsible for Account: ____________________

E-Mail Address: ____________________

Current Address: ____________________ Employed By: ____________________

Business Address: ____________________ Business Phone #: ____________________

Date of Birth: ____________________ Social Security Number: ____________________

Insurance Co. Name: ____________________ Phone Number: ____________________

Company Providing Insurance: ____________________

Name of other Family Members:

____________________ ____________________

____________________ ____________________

I UNDERSTAND THAT A FINANCE CHARGE WILL BE ACRUED ON ACCOUNTS OUTSTANDING OVER 60 DAYS. OUR OFFICE MAY OBTAIN A CREDIT REPORT TO FACILITATE MAKING FINANCIAL ARRANGEMENTS.

Signature of person responsible for account: ____________________ Date: ____________