CLIENT INFORMATION

Name: _____ Age: _____ Birthdate:_____
First M.I. Last

Mailing Address:

_____
Street City State Zip

Home Phone: _____ Cell Phone: _____
Message ok?: Yes No *Message ok? Yes No*

Which phone would you prefer I use to contact you?_____

How would you like to receive your appointment reminders? (Pick one, please)

_____Automated call to:_____

_____Text to: _____

_____Email to this address: _____

Employer: _____Occupation:_____

Relationship Status: _____Date of Marriage/Relationship: _____

Partner's Name: _____Partner's Date of Birth: _____

Partner's Employer: _____

Children (Names and ages): _____

_____

Referred by: _____ Family Physician:_____

Current Medications:_____

_____

_____

Current Health Conditions: _____

_____

_____

In an emergency, notify: _____ Relationship: _____

Phone Number: _____

If you are **not** the subscriber on your insurance, please list the name and date of birth of the person who is the subscriber.

Name:_____Birthdate:_____

I hereby authorize this office to furnish information to insurance carriers concerning my treatment and I hereby assign all payments to you for services tendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not paid by insurance. A photocopy of this authorization and assignment shall be considered as valid and original.

Signature: _____

Date: _____