ADULT PATIENT INFORMATION SHEET

_____. _____. _____.
Patient's Name (First/Middle/Last) Date of Birth Social Security #

_____.
Address: (Street/City/State/Zip)

_____. _____. _____.
Employer Occupation Business Phone #

_____.
Business Address: (Street,City/State/Zip)

_____ _____.
E-Mail Address Cell Phone #

Marital Status: ( )Single ( )Married ( )Divorced ( )Widow/Widower ( )Partnered

_____.
Spouse/Partner's Name (if applicable) Cell Phone # E-Mail Address

REFERRAL SOURCE: (Please give address & phone #, if known):

_____.

In case of emergency, contact:

_____.
Name Relationship Phone Number

Pharmacy: _____.
Name Phone Number Fax Number

RESPECTFULLY, A 24 HOUR CANCELLATION NOTICE IS REQUIRED: OTHERWISE, YOU WILL BE CHARGED

There is a $35 charge for replacing a prescription between appointment times during business hours and $50 charge per RX during evening, holiday and weekend hours.

PERMISSION TO PROVIDE SERVICES/RESPONSIBILITY FOR PAYMENT: I hereby grant permission to H. William Martin, M.D. to provide services to the person listed above and do hereby accept full and complete responsibility for all debts and obligations incurred during the course of said patient's treatment.

_____. _____. _____.
Signature of Responsible Party Signature of Patient Date