# WELCOME !

## *Confidential Patient Information*

Today's Date: ______________________________

Name: ________________________________________________________________________________

*Last* *First* *Middle*

Birth date: ____ /____ /________ Age: ________ Social Security# (optional)________________________

Address: ____________________________________________________________________________

Street / P.O. Box

City: ________________________________________________ State: ___________ Zip: _______________

Email: ______________________________________________________________________________

Home Phone: (____)__________________ Work Phone: (____)_________________ Ext. ________________

Employer: ____________________________________ Occupation: ______________________________

Emergency Contact: ______________________________ His/Her Phone #: (____)___________________

Referred By: _________________________________________________________________________

*If you are here for treatment of injuries related to an accident , please circle where the accident occurred :*

Auto Work Home Other : __________________________________________________________

Please briefly describe the health problem for which you came to our office :

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Are you interested in nutritional information or advice? O YES O NO

Please read and sign below:

I understand that I am responsible for payment of all charges, including deductibles, co-pays, and procedures not covered by my insurance policy.

I hereby authorize the release of my medical records to my insurance company for the express purpose of payment for my medical bills incurred in this office.

I hereby authorize the insurance company or attorney to remit payment directly to this office.

I understand there is a 24 hour notice required in order to cancel or reschedule an appointment, or I will be charged.

Signature: ____________________________________________ Date: ______________________________