

Patient Information

Patient Name:

Address:

City:

State:

Zip:

Home phone #

Work #

Cell phone #

Email:

Occupation:

Employer:

Social Security #

Driver's License #

Date of Birth:

Age:

M / F

Diagnosis:

Major Symptoms:

Your personal physician:

Phone #

Emergency contact:

Phone #

Who may we thank for the referral ?

How would you prefer to handle payment: (check one) Cash Check Credit card

It is customary to pay for professional services when rendered. This office does not handle insurance billing procedures. However, our office will gladly provide you two copies of a "superbill" statement of all charges for professional services, including diagnostic and treatment codes. It is the patient's responsibility to submit a copy of the statement to their insurance company for reimbursement.

SIGNED: _____

DATE: _____