

Office FW M C

PATIENT INFORMATION

For Patients under 18 years of age

_____ Date

_____ Referred by

_____ Account Number

Name: _____ Sex: M F Age: _____ Date of birth _____
First Middle Last

Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____ S.S. No: _____

Phone No: (____) _____ School Attending/Town: _____

Primary Physician: _____ Address/Phone: _____

Parent or Guardian: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ S.S. No: _____ Drivers Lic. No: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext. _____

E-Mail Address: _____

Employer: _____ Occupation: _____

Parent or Guardian: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ S.S. No: _____ Drivers Lic. No: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext. _____

E-Mail Address: _____

Employer: _____ Occupation: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you

Name: _____ Home Phone: (____) _____ Work Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail Address: _____

I hereby give my permission to treat the above named patient.

I understand that I am legally responsible for all charges incurred for the care of the above named patient. Payment is expected when service is rendered unless alternate arrangements have been made in advance. There will be a charge of \$20 for any returned checks. I understand that where appropriate, Credit Bureau reports may be obtained.

Notice to All Patients, and Responsible Parties:

I understand, and agree that interest will accrue on any outstanding balance older than three, (3), months from the date of service.

Signature: _____ Date: _____

Parent or Legal Guardian