Confidential Patient History:

Name _____ Date _____

Mailing Address _____ City _____ ZIP _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

E-mail _____ Date of Birth _____

Please circle salutation: Mr. Mrs. Ms. Miss Master Dr. Rev. SSN _____-____-_____

Employer _____ Occupation _____

Person Responsible for Account _____ Relationship to Patient _____

Address _____ City _____ ZIP _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Whom may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you hear about our office? _____

Payment Terms:

Office policy calls for payment at time of service.

We are happy to assist you if you need help filing your insurance claim.

We accept CASH, PERSONAL CHECKS, MASTERCARD, VISA,
AMERICAN EXPRESS and DISCOVER.

Signed _____ Date _____