POLICY AND PATIENT DATA

1. Payment is due at the time of service, unless other arrangements have been made.
2. An INSURANCE CONTRACT is between the patient and the patient's insurance company; therefore it is the responsibility of the patient to keep the account current.
3. Patients involved in LITIGATION (law suits) are, as others, responsible for their services here at the clinic.
4. We reserve the right to BILL FOR MISSED APPOINTMENTS.
5. Personal cleanliness is requested due to the close personal nature of this work.
6. SMOKING IS PROHIBITED.

Please Write Legibly

Patient Name: _____ Tel.(Home) ( ) _____
Address: _____ Tel.(Work) ( ) _____
_____ Tel.(Other) ( ) _____
Previous Address: _____
Birthdate: __/__/____ Age: _____ Height: _____ Weight: _____
SSN: ___-___-_____ Driver's License # _____
Occupation: _____ Employer: _____
Employers' Address: _____
Name of Spouse: _____
Spouse's Occupation: _____ Spouse's Employer: _____
In case of emergency whom shall we notify? _____ **Phone:** _____

My Signature is an acknowledgement that I have read the policies above and agree to abide by the same

Patient Signature: _____ **Today's Date:** _____

If the patient is a minor. Permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient. I am his/her legal guardian.

Guardian Signature: _____ **Today's Date:** _____

IF YOU HAVE HEALTH INSURANCE, PLEASE FILL OUT BELOW

Name of Insured (if patient is a dependent): _____
Employer of Insured: _____ Group No.: _____
Name of Insurance Policy: _____ I.D. No.: _____
Billing Address: _____ Tel. No.: _____

****

FOR OFFICE USE ONLY:

Diagnosis: _____ Treatment: _____