Office FW M C

Referred by

PATIENT INFORMATION

For Patients under 18 years of age

Date

Account Number

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

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: Parent or Legal Guardian Date: