

## Patient Information Form

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Spouse's Name and Number: \_\_\_\_\_

Nearest Relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest Friend not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Landlord: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we contact in the case of an emergency?

\_\_\_\_\_ Phone: \_\_\_\_\_

I will be paying today by cash: \_\_\_\_\_ check: \_\_\_\_\_ credit card: \_\_\_\_\_ debit: \_\_\_\_\_

**I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent (if minor)

\_\_\_\_\_  
Date