

CLIENT INFORMATION

Client's Name	Marital Status	Date of Birth	Social Security #
Street Address	City/State	Zip Code	Home Phone # Cell #
Client's Employer	Occupation (Indicate if Student)	How long employed?	Business Phone #
Employer's Address	City/State	Zip Code	Client's Driver License #
In case of emergency, contact (name, relationship and phone number):			
Spouse's Name			
Spouse's Employer	Occupation (Indicate if Student)	Business Phone #	
Employer's Address	City/State	Zip Code	
Who referred you to this practice?			Primary Care Physician
			PCP phone number

IF THE CLIENT IS A MINOR OR STUDENT

Parent 1/Guardian Name	Address/City/State/Zip Code	Home Phone #	Cell #
Parent 1/Guardian Employer	Occupation (Indicate if Student)	Business Phone #	
Employer's Address/City/State/Zip Code		Parent 1/Guardian Driver's License #	
Parent 2/Guardian Name	Address/City/State/Zip Code	Home Phone #	Cell#
Parent 2/Guardian Employer	Occupation (Indicate if Student)	Business Phone #	
Employer's Address/City/State/Zip Code		Parent 2/Guardian Driver's License #	

I understand that I am responsible for all charges, whether or not covered by insurance, and that payment is due at the time services are rendered.

Signature: _____ Date: _____