Welcome To Our Office

Name ____ Date __________________

Address ____

City ___________________________ State _______________ Zip ___________

Age ______ Birth date _________________ Phone __________________________

Email ____

Type of Work __________________________________ Student ____ Full/PT ____

Employed By ________________________ Business Phone ___________________

Medical Doctor's Name ____

Address _____________________________ Phone __________________________

When was your last visit? ____

In case of emergency, who should be notified? ________________________________

Phone ________________________________

How did you hear about this office? ____

I hereby give permission to the Doctor to administer treatment and perform such general procedures as is necessary in the diagnosis and/or treatment of my condition. <u>I understand that the care provided is on a cash/check/credit card basis and payment is expected at the time of each visit.</u> I will be provided with a receipt of services and payment, which may be sent to my insurance company for appropriate reimbursement.

Patient's Signature _____________________________________ Date ___________

Guardian Signature authorizing care ____