NAME:_____MALE_____FEMALE_____

ADDRESS: _____CITY:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____

E-MAIL ADDRESS:_____BIRTHDATE:_____SS#:_____

DL#:_____EMPLOYER:_____OCCUPATION:_____

STATUS:MINOR____ SINGLE____ MARRIED____ DIVORCED____ WIDOWED____

SPOUSE NAME:_____REFERRED BY:_____

EMERGENCY CONTACT NAME AND NUMBER:_____

INSURANCE INFORMATION—PLEASE PRESENT INSURANCE CARD

SUBSCRIBER NAME:_____SS#_____

BIRTHDATE:_____EMPLOYER:_____

INSURANCE CO:_____PHONE #:_____

GROUP #:_____INSURANCE ID #:_____

PERSON WITH FINANCIAL RESPONSIBILITY:_____

I UNDERSTAND AND AGREE (REGARDLESS OF MY INSURANCE STATUS), THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. IF MY ACCOUNT IS NOT PAID WITHIN 90 DAYS OF THE DATE OF SERVICE, I WILL BE RESPONSIBLE FOR LEGAL FEES, COLLECTION AGENCY FEES, INTEREST CHARGES AND OTHER EXPENSES INCURRED IN COLLECTING ON MY ACCOUNT. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN THE ABOVE IMFORMAITON. I AUTHORIZE THE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSES AND TEATMENT. I ASLO AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

SIGNATURE_____DATE_____