Client Information

Client:

Your Name:_____________________________Date of Birth:_________Age:____

Address:_____________________________City:___________State:___Zip:_____

Email:_______________________________________SS#:___________________

Home/Evening phone:___________________Cell Phone:____________________

Calls will be discreet, but please indicate any
restrictions:____

Referral:

Who gave you my name to call?_______________________Phone:____________

May I have permission to thank this person for the referral?___Yes ____No

Your Current Employer:

Employer:____

Address:____

Work Phone:_______________________________Calls will be discreet, but please indicate any
restrictions:____

I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account to secure timely payment to the assignee or myself.

I understand that I am responsible for all charges, regardless of insurance coverage. A medical superbill can be provided upon request for possible out of network provider benefits.

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Clients (or parent/guardian's) signature, Date

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Please print name