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PATIENT INFORMATION SHEET

Name _____ Age _____ DOB _____

Address:_____ Zip Code _____

Social Security Number _____ Email:

Home Phone _____ May we leave a message? Y N

Work Phone _____ May we leave a message? Y N

Mobile Phone _____ May we leave a message? Y N

Employer _____ Occupation _____

Education _____ Religion _____

Marital Status: single married domestic partnership separated divorced widowed

Name of Spouse/Partner _____ DOB _____

Occupation _____ Religion _____

Spouse/Partner Contact Phone _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____

Please list individuals living in your household (include minors/children):

Name	Relationship	Age	Occupation

Please list all family members not living in your present household (including parents, siblings, children, separated/divorced partners)

Name	Relationship	Age	Occupation

_____

How were you referred? _____

Please briefly describe the problem or situation that has lead you to seek treatment:

_____

_____

Have you ever experienced this problem before? If so, when and what treatment did you receive?

_____

_____

Do you have any particular treatments in mind? If so, what? _____

_____

Name of PCP: _____

Names of other current treating providers: _____

_____

YOU WILL BE CHARGED FOR MISSED APPOINTMENTS UNLESS YOU PROVIDE 24-HOUR NOTICE. PLEASE NOTE THAT INSURANCE WILL NOT REIMBURSE FOR MISSED APPOINTMENTS. BY SIGNING, YOU AGREE THAT ALL CHARGES ARE YOUR RESPONSIBILITY AND THAT FILING FOR OUT-OF-NETWORK INSURANCE REIMBURSEMENT IS YOUR RESPONSIBILITY IF YOU CHOOSE TO DO SO.

Signature of Guarantor:_____ Date: _____

Guarantor Name: _____

Address: _____ Zip: _____

Relationship to Patient: _____Employer: _____

Employers Address: _____

If different from patient information above:

Home No: (_____)_____

Business No: (_____)_____

Cell No: (____)_____