GENERAL INFORMATION

Patient Name:______________________________ Name you prefer to be called:______________

Title: Mr. Mrs. Miss. Ms. Dr. Family Status: Married Single Child Other

Date of Birth:_____________________ Social Security Number:_____________________

Address:_____________________________ City:_______________________ Zip:______________

Home Phone:________________________ Email:________________________________
Cell Phone:__________________________
Work Phone:________________________ Employer or School:___________________
May we call you at work? Y N

Whom may we thank for referring you to our office?_____________________________________

PERSON FINANCIALLY RESPONSIBLE (if different from above)

Name:____ Date of Birth:________________________

Social Security Number:________________________ Relationship to Patient:________________

Address:_____________________________ City:_________________________ Zip:_____________

Home Phone:__________________ Cell Phone:_________________ Work Phone:______________

CONSENT

I, ___________________________________ grant permission to Drs. Patel/Dornhecker and their staff to contact and discuss my treatment, financial obligations and insurance submission with my: SPOUSE PARENT(S)/LEGAL GUARDIAN OR _______________________________
(Circle which applies)

Signature:____ Date:____________________________

EMERGENCY CONTACT

Name:______________________________________ Relationship to Patient:___________________

Home Phone:_________________ Cell Phone:________________ Work Phone:________________

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