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PLEASE PRINT OR WRITE CLEARLY

(H)_____

Date:_____ Phone: (W)_____

Patient:_____ Age: _____ D.O.B.: _____ (C/M)_____

_____ _____
(If patient is a minor or incapacitated, name and relationship of legally responsible adult) (Who you were referred by)

Address:_____
Street City State ZIP

Occupation: _____ Employer:_____

Work address: _____ZIP:_____

Please list those who live with you:

Name	**Relationship**	**Occupation or Grade in School**

Are you covered by any insurance or health care plan? ☐ Yes ☐ No ☐ I don't want to use my health plan..

If ***yes***, name of plan #1:_____ ID#; _____ Gp.#:_____

Secondary Plan: _____ ID#; _____ Gp.#:_____

Subscriber Name:_____ Subscriber ID # :_____

Subscriber DOB:_____ Relationship:_____

Please submit your insurance cards for photocopying.

Please list all current medical conditions including recent hospitalizations and dates: _____

_____

_____

Current medications:_____

_____

I hereby give my consent for treatment: _____

signature of patient or legally responsible adult