

Policy and Patient Data

1. **PAYMENT** is due at the time of service, unless other arrangements have been made.
2. An **INSURANCE CONTRACT** is between the patient and the patient's insurance company; therefore it is the responsibility of the patient to keep the account current.
3. Patients involved in **LITIGATION** (lawsuits) are, as others, responsible for their services here at the clinic.
4. Personal cleanliness is requested due to the interpersonal nature of this work.
5. Please **TURN OFF** cell phones when in the treatment rooms.

Patient Name (First and Last)		Home Phone		Work Phone	
Street Address		City		State	Zip
By Whom were you referred?		Birth date	Age	Height	Weight
Social Security #	Driver's License #		*E-mail Address		
Occupation	Employer		Employers Address		
Primary Care Physician/Pediatrician's Name And Phone Number					
Spouse's Name		Spouse's Birth date		Spouse's Occupation	
Spouse's Employer			In the event of an emergency, whom should we notify?		
Relationship to Patient			Daytime Phone		

*E-mail address will not be shared. Will be used for communication regarding office/educational information only.

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY THE SAME.

Patient Signature:	Date	Witness Signature
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AUTHORIZATION FOR CARE OF A MINOR

Parent(s)/Guardian Names	Work Phone	Cell Phone
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IF PATIENT IS A MINOR: Permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient.

Parent(s)/Guardian Names	Date	Witness Signature:
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