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)		Birthdate	Age	Social Security #
Address	City		State	Zip
Home and cell Phone #	Work Phone #		*E-mail Address	
By whom were you referred?				
Occupation	Employer	Employers Address		
Primary Care Physician/Pediatrician's Name And Phone Number			Height	Weight
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

AUTHORIZATION FOR CARE OF A MINOR

Parent(s)/Guardian Names	Birthdate of Insured	Work Phone	Cell Phone

*Primary Insured's birthdate must be submitted to insurance.

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: