

**THIS SHEET MUST BE FILLED IN COMPLETELY**

**Please Print Clearly**

Date \_\_\_\_\_  
Client's First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Gender \_\_F\_\_M  
Name of Spouse: \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person Responsible for Payment \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Signature of Person Responsible for Payment **X** \_\_\_\_\_ (Must be signed for services to begin)

**Emergency Information**

In case of emergency, contact:  
Name (1) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Work \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Current Medications \_\_\_\_\_  
\_\_\_\_\_

Allergies \_\_\_\_\_

Current Medical Problems: \_\_\_\_\_

**Employment Information**

Name of employer: \_\_\_\_\_ Phone \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Phone \_\_\_\_\_

**Referral Source**

How did you hear about the practice (or from whom)? \_\_\_\_\_