

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

Mother's Name _____ Work/Cell Phone: _____
Address _____ City _____ State _____ Zip _____

Father's Name: _____ Work/Cell 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 _____

School Information

Name of School _____ Grade _____
School Counselor _____ Phone _____

Referral Source

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