Patient Name: ____
Last Name First Name MI

Address: ____
Street Address City State/Zip

Contact Phone Numbers: Home: ( ) ______________ Cell: ( ) ________________ **Marital Status: S M W Other**

E-Mail Address: ___________________________ **Date of Birth:** ___/____/___ **Age:** _______ **Height:** _______ **Weight:** _______

*<u>***Would you like to receive emails regarding specials/promotions from our office:***</u> ***YES / NO***

<u>OCCUPATION</u>: _______________________ Employer**:** ____

Work Phone Number: ( ) _______________________ Address: ____

<u>NAME OF SPOUSE</u> (Parent if patient is a minor): ____________________________Occupation: ________________________

Employer: ____Work Phone: ( ) _____________________________________

<u>EMERGENCY CONTACT INFORMATION</u>: Name: ___________________________ Phone Number: ( ) _________________

Relationship to you: Spouse / Friend / Parent / Other: _______________________

<u>FAMILY PHYSICIAN INFORMATION</u>: Physician's Name: _______________________Phone Number: ( ) ______________

Address: ____

<u>I heard about Dr. Clark through: (Check any and all that apply):</u>

____ Physician ____ Friend ____ Another Patient ____ Website ____ Newsletter ____ Radio____ TV ____ Yellow Pages

____ Publication (which one?) ______________________________

***Name of Physician/Friend/Patient:** ____

SIGNATURE: ____ **DATE:** ______________________

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.