



If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

Patient Contact

Last name	First name	Middle initial
Street		
City	State	Zip
Home phone	Mobile phone	
Work phone	e-mail	

Patient Personal

Age	Date of birth	Social Security	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Partnered	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced

Emergency Contact

Name	Home phone
Relationship	Work phone

Spouse or Guardian

Last name	First name	Middle initial
Employer name		
Work phone	Home phone	

Patient Employment

Employer name	Occupation	
Street		
City	State	Zip

Which one of our patients referred you to the clinic?

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes, and I am requesting these services if necessary.
- My case may not be accepted for treatment at this clinic.
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost.

patient or guardian signature

date