Patient Information Sheet

Date:	Last Name:	First Name:	Preferred Name:	Social Security Number:
Gender: M □ F □	Date of Birth:	Age:	Marital Status: Single □ Married □ Divorced □ Widow □	
Address:			City:	State: Zip:
Home Phone:	Work Phone:		Cell Phone:	
Emergency Contact & Relationship			Phone Number of Emergency Contact Primary: Alternate:	

Please Answer the Following Question:

	Yes	No		Yes	No
Do you have a tendency to faint?	□	□	Are you HIV +?	□	□
Do you have a pacemaker?	□	□	Are you pregnant? (Woman)	□	□
Do you bleed for a long time?	□	□	Have you ever had Hepatitis?	□	□

Medication: Please list all prescription medications you use. Include those which you may only use occasionally:						
Prescription Name:		Purpose:	How Long	Dose	How Often	Last Dose

Our Office Policy

1. For most cases we do not bill insurance directly. Patients are expected to take care of their fees as services are rendered. We do not accept responsibility for collecting your insurance claims or for negotiating a settlement of a disputed claim. However, we will gladly prepare a doctor's statement of charges for you to submit to your insurance carrier for reimbursement.
2. If you need to cancel an appointment, *please inform us **at least 24 hours** in advance to avoid a full charge of service.* A missed appointment will also be charged at full fee.
3. There is a service charge of $25 for every returned check.
4. I authorize the release of any medial records and/or any other necessary information to process a claim with my insurance.

I have read and agree to the terms of the preceding paragraphs. All information presented is true to the best of my knowledge.

Patient's Signature _____ Date _____