Patient Information

Patient Name: ____

Date of Birth: ____

Parent/Guardian Name if patient is a minor: _______________________________________

Street Address: ____

City/State/Zip: ____

Email: ____

Home Phone: ________________________**Cell Phone:** ___________________________

Please check preferred contact number: ______ **Home phone** ______ **Cell phone**

Would you like a text appointment reminder sent to your cell phone ? ____**Yes** ____**No**

How did you hear about us? ____

Best Way to Contact You (check all that apply):

____ Speak only to me   _____ Leave message on home answering machine

____ Leave message on cell phone   _____ Leave message with family member

Emergency Contact Information

Name of Emergency Contact and Relationship: _______________________________________

Phone Number: ____

Patient Signature that the above is true and you agree to treatment:
(parent/guardian please sign if patient is a minor):

____   _________________________

Signature   Date