

Patient Information

Patient Name:	Date of Birth:		
Street Address:			
City/State/Zip:			
Email:			
Home Phone:	Patient Cell Phone:		
Please check preferred con	tact number: Home	phone Cell	ohone
Would you like a text appo	intment reminder sent to your o	cell phone ?Yes	No
How did you hear about us?			
	Leave message on Leave message wit Leave Contact Information	home answering machine h family member	
Name of Emergency Contac	t:		
Phone Number:			
If the Pa	atient is a minor, please comple	te the section below:	
Parent/Guardian Name:			
Parent/Guardian Contact	Phone Number:		
Please circle who we sho	uld text for appointment reminders:	PARENT/GUARDIAN	PATIENT
Patient Signature that the ((parent/guardian please sig	above is true and you agree to t gn if patient is a minor):	reatment:	
Signature		Date	