# New Patient Information

Name: _____

Address: _____

Phone:

Home: _____

Cell: _____

Phone Preference for Communications: _____

Email Address: _____

Date of Birth: _____

Social Security No.: _____

Marital Status: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone: _____

Pharmacy Preference: _____

Please Check One:

[ ] Insurance or [ ] Self Pay

Subscriber on insurance policy if other than yourself: _____

Subscriber DOB: _____

Subscriber Address: _____

- If you don't have insurance the initial visit is $100 and every subsequent visit is $60.
- Co-payment is due at time of service.