

Client Information

Personal Information

Name _____ Drivers License # _____

Home Address _____

City/State/Zip _____

Home Phone _____ Date of Birth _____

Phone you would like to receive calls: _____

Social Security Number _____ Marital Status _____

Occupation _____ Employer _____

Name of Spouse/Partner _____

Name of Children and ages: _____

If Client is a Minor

Parent or Guardian _____

Address _____

City/State/Zip _____

Person Responsible for Account _____

The undersigned accepts responsibility for the cost of all services rendered to the patient and attests that the information given is true and correct. The undersigned further understands that APPOINTMENTS MUST BE CANCELLED ONE FULL BUSINESS DAY PRIOR TO THE SCHEDULED TIME OR THE LATE FEE OF \$60.00 WILL BE CHARGED.

Signature

Date