# PATIENT INFORMATION

Please complete ALL sections in print or block letters.

**PATIENT NAME:** ________________________________________________

Last Name First Name MI

**ADDRESS:** ________________________________________________

Street Address City State/Zip

**Would you like to receive mailings from our office YES NO**

**CONTACT PHONE NUMBERS:** **Home: ( ) ____________________ Cell: ( ) ____________________**

**E-Mail Address: ____________________________________Marital Status: S M W Other**

**Date of Birth: ______________________Age: _________ Height: ___________ Weight: ______________**

**Social Security Number: ________________________Driver's License Number:___________________**

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**OCCUPATION:** ___________________________ **EMPLOYER:**_____________________________________

**Work Phone Number:** ( ) ________________. **Address:**________________________________________

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**NAME OF SPOUSE (Parent if patient is a minor) :**________________________________________

**Occupation:** ___________________________ **Employer:**_________________________________________________

**Work Phone:** _____________________________

**Parent Social Security Number:**____________________**Parent Driver's License Number:**_____________________

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**EMERGENCY CONTACT INFORMATION: Other than Spouse/Parent:**

**Name:** _______________________________________ **Phone Number:** ( )____________________

**Relationship to you: Spouse / Friend / Parent / Other:**__________________________________

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**FAMILY PHYSICIAN INFORMATION: Physician's Name:**________________________________

**Phone Number:** ( ) ____________________**Address:**_______________________________________________

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**I HEARD ABOUT DR. CLARK THROUGH (Check any that apply):**

**_____ Physican * _____ Friend* _____ Another Patient* _____ Website_____ Newsletter _____ Radio**

**_____TV _____Yellow Pages _____ Publication (which one?) ___________________________________________**

***Name of Physician/Friend/Patient:______________________________________________________________**

**SIGNATURE**: ______________________________________**DATE:**_______________________

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.