ABOUT YOU

Today's Date:_____

Name:_____
_____
Last First Mi Mr. Mrs. Ms. Dr.

I prefer to be called:_____

Birthdate:_____/__ _____/_____
Age:_____

☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Home Address:_____
_____
Street City State Zip

Home Phone # (_____**)**_____**-**_____ **Cell/Pager # (**_____**)** _____**-** _____

Where & when are the best times to reach you?_____

Email address:_____
_

Whom may we thank for referring you?_____

Employer:_____**How long there?**_____

Occupation:_____

Employer's address:_____

_____

Street/P O Box **City** **State** **Zip**

Please list any serious medical condition(s) that you have experienced:_____

PHASE4 APPOINTMENT CANCELLATION POLICY: Appointments must be cancelled within 12 hours of your appointment time. Failure to do so will result in a penalty of 50% of the service charges for your non-cancelled appointment added to the charges for your next visit.