

New Client Information Form

Please fill out the following:

Last Name _____ First Name _____
Spouse / Other _____ Email _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Other (Fax, Pager, Cell) _____

Occupation _____
Employer _____ Phone _____
Spouse's Occupation _____
Employer _____ Phone _____

How did you select our hospital (ie. Yellow Pages, Personal Referral)?:
_____ If referred by one of our clients,
Please enter name _____

Please enter the following:

Circle One: Visa Mastercard Discover
Credit Card No. _____ Exp. Date _____ / _____
Driver's License _____
Spouse's Driver's License _____

All fees must be paid in full at the time they are performed. Please feel free to ask what services will cost in advance, and we will be glad to fill out a complete estimate for you. Any delayed payment will incur an 18% interest fee.

Signature _____ Date _____ / _____ / _____