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PLEASE COMPLETE IN FULL / PRINT CLEARLY

Patient's Full Name (Last, First, Middle Initial): _____, _____, _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Where May We Contact You? Home Work Cell

Patient's Date of Birth: _____ Age: _____ Social Security #: _____

Marital Status (circle one): single / married / widowed / separated / divorced Sex: Male / Female

Driver's License Number: _____ Patient here before? Yes No

Employer: _____ Full Part time Occupation: _____

Spouse's Employer: _____ Occupation: _____

Person Responsible for Account: _____ Relationship to Patient: _____

Address (if different): _____ City/State/Zip _____

Home Phone (if different): _____ Work Phone: _____

Name and Phone Number of closest relative/friend NOT living with you: _____

Emergency Contact: _____ Relationship to patient _____

Emergency Contact Phone # _____

How Were You Referred To This Office? _____

In the unfortunate event that this account is assigned to any attorney for collection and/or suit, the prevailing party shall be entitled to any and all attorney's fees and costs of collection. Also, an additional fee of 40% of the amount owed will be added for collection charges.

Please be sure to review and acknowledge The Happy Mind Company's Financial, Medication and Practice Policies, found at the end of this packet.

*IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, PLEASE GIVE 48 HOURS NOTICE
A \$75.00 CHARGE WILL BE IMPOSED FOR THE TIME RESERVED.*

I certify that all information on this page is true. I have read and understand and agree to the above.

Signature: _____ Printed Name: _____

Relationship to Patient: _____ Date: _____

***If legal guardian, please present guardianship paper to receptionist**