

Welcome

Patient Information

Name _____ I prefer to be called: _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work # _____ Ext _____ Cell # _____

E-Mail Address _____ Social Security # _____

Sex M F Birthdate ____/____/____ Single Married Separated Divorced Widowed

Employer _____ Occupation _____

Employer Address _____ How long there? _____

Preferred method to be contacted: Home phone Work phone Cell phone E-mail (please Circle)

Spouse Information

Spouse's Name _____

Spouse Social Security # _____ Birthdate ____/____/____

Spouse Employer _____ Phone # _____

Responsible Party

Name _____ Relationship _____

Billing Address _____

Home # _____ Work # _____

I understand that I, not my insurance company, am responsible for payment in full for all care. Should my account become delinquent, I understand that I will also be responsible for all collection fees as well as reasonable attorneys' fees. I also understand that unless Dr. Brody's office is notified at least 24 hours in advance, the policy is to charge for missed appointments at a rate of \$75.00 per 30 minutes of appointment time scheduled.

Date: _____ Responsible Party Signature: _____

Whom may we thank for referring you _____