Patient Demographics

Patient Information

Last Name ________________ First Name ________________ MI ____

Mailing Address (street #, street name, city, state, zip code) ________________

(   ) ________________ Primary Phone Cell ___ Home ____

(   ) ________________ Alternate Phone

DOB _____________ ____Male ____Female __ Single __ Married __ Divorced __ Widowed __Partner

Email ________________

Occupation ________________

Employer Name ________________

(   ) ________________ Employer Phone Number

Employer Address ________________

Patient Contact Information

Emergency Contact Name ________________

(   ) ________________ Emergency Contact Phone Number

Primary Care Doctor ________________

(   ) ________________ Phone Number

Patient Insurance (unless using selfpay)

Insurance Provider ________________

Primary Subscribe Name – Relationship to patient ________________

Policy # ________________

Group # ________________

I verify that the above information is true to the best of my knowledge. I authorize Dr. Cark to employ any necessary treatments. I agree to pay any costs that are not covered by insurance or if I am self-pay at the time of treatment or when billed.

Patient Signature/ Guardian Signature if patient is under 18 ________________ Date ________________