New Client Information Form

Please fill out the following:

Last Name _____ First Name _____

Spouse / Other _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Other (Fax, Pager, Cell) _____

Email Adress: _____

Would you like to receive our newsletters, updates, appointment reminders, etc. via email? Yes / No

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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: _____

_____

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 incure an 18% interest fee.

Signature _____ Date ____ / ____ / ____