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REGISTRATION FORM

NAME _____

ADDRESS _____ APT # _____

CITY/STATE/ZIP _____

PHONE _____ CELL PHONE _____ EMAIL ADDRESS _____

AGE _____ Referred By: _____

BIRTH DATE _____ SOCIAL SECURITY NO. _____

INSURANCE NAME _____ INSURANCE# _____ GRP# _____

OCCUPATION _____

EMPLOYER NAME/ADDRESS _____

EMPLOYER PHONE _____

SPOUSE NAME _____ SPOUSE'S EMPLOYER & PHONE _____

CHILDREN'S NAME/AGE: _____

LIST DOCTORS AND ANY MEDICATION YOU ARE TAKING: _____

LIST ALL OVER THE COUNTER MEDICATIONS:

DO YOU SMOKE? _____ WHAT BRAND? _____ HOW MANY PER DAY? _____

DO YOU DRINK CAFFEINATED BEVERAGES? _____ WHAT KIND? _____ HOW MUCH? _____

DO YOU DRINK ALCOHOLIC BEVERAGES? _____ WHAT? _____ HOW OFTEN? _____

WHAT WOULD YOU LIKE HELP WITH? _____

SIGNATURE _____ DATE _____

**PAYMENT IS DUE AT TIME OF SERVICE
FULL FEE WILL BE CHARGED FOR APPOINTMENTS CANCELED WITH LESS THAN 24 HOURS NOTICE.**