

## PATIENT INTRODUCTION

Date: \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Gender:  male  female Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Marital Status:  single  married Race or ethnic background: \_\_\_\_\_  
 separated  divorced \_\_\_\_\_  
 widowed  significant other \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Personal e-mail Address: \_\_\_\_\_

### Employment Information

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Website: \_\_\_\_\_

Nearest relative not living with you:

\_\_\_\_\_ Phone Number \_\_\_\_\_

Who can we contact in case of an emergency?

\_\_\_\_\_ Phone Number \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

\_\_\_\_\_ I understand that Dr. Francis does not accept insurance assignment and that I am responsible for all fees incurred under her care. If I wish to have insurance payment, I will submit my receipts for reimbursement myself.

\_\_\_\_\_ I understand that due to the extended length of visits under the care of Dr. Francis, that it is necessary to cancel my appointment 24 hours in advance or I will be charged full price for the visit at the discretion of Dr. Francis. However, if my appointment is able to be filled by Dr. Francis or me, I will not be charged.

\_\_\_\_\_ I wish to receive Dr. Francis' e-newsletter.

\_\_\_\_\_  
Please sign your name