

Patient Information Form

Patient Name: (Last) _____ (First) _____ (MI) _____

Mailing Address: _____

City: _____ ST: _____ Zip: _____

Preferred Contact Phone Number: _____ 2nd phone: _____

Email address: _____

I would like my appointment reminder sent to the email address above: Yes / No

I would like my appointment reminder sent to the phone number above: Yes / No

Employment Information:

Current Employer: _____ Occupation: _____

Employer Address: _____

Work Phone: _____

Social Security: _____ Drivers License: ST _____ Number _____

In Case of Emergency:

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: _____

Financial Policy:

Thank you for selecting Dr. Dawn D Rhodes-Hicks for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at or prior to the time services are rendered. Insurance does not cover aesthetic or weight management services, but you may submit a receipt to your insurance company for possible reimbursement.

I have read and understand all of the above and have agreed to these statements.

Patients Name Printed & Signature

Date