NEW PATIENT REGISTRATION FORM

(Please complete all areas of form)

PATIENT INFORMATION

Patient Name: ____

Address:____

Email:______________________________Cell:________________

Date of Birth: __________Gender____Partner Name/Status__________________

Children/Names & Ages____

Employer: ____

Occupation: ____

Emergency Person/Relationship & Contact Number:______________________

Primary Care Physician__________________Phone#:________________

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR PAYMENT (if not the patient):__________________

Relationship ________________Contact #:__________________

I AUTHORIZE DR. LINDA LIFUR-BENNETT TO CHARGE THE BELOW CREDIT CARD ACCOUNT FOR PROFESSIONAL SERVICES:

FULL NAME (as it appears on the credit card)

______________________________ CELL NUMBER________________

CARDHOLDERS BILLING ADDRESS

__________________CITY ________STATE __________BILLING ZIP CODE

VISA( ) MC( ) AE ( ) CARD NUMBER______________________________

EXP DATE ________ DIGIT SECURITY CODE __________

SIGNATURE______________________________DATE________________