File #_____

TUSTIN HOLISTIC HEALTH

JOHN R. ENNEN DC

CONFIDENTIAL INFORMATION FOR YOUR FILE
All your information remains confidential. We appreciate your cooperation in completing this form.

Today's Date _____

Patient Name _____Age _____Birth-Date _____Sex_____

Address _____ City _____ State _____Zip _____

Home phone No_____Cell phone No_____Social Security No._____

Marriage Status □ M □ S □ W □ D No. of Children _____

Driver's License No._____ Email Address_____Occupation_____

Employer's Name_____ Employer's Phone_____Years Employed_____

Employer's Address _____

Spouse / Significant Other's (SO) Name _____ Spouse / SO's DOB_____

Spouse / SO's Employer_____Spouse / SO's SS # _____

Spouse / SO's Employer's Phone_____Spouse / SO's Phone No_____

Email Address _____

In case of Emergency, nearest friend or family:

Name:_____Relationship to Patient_____

Phone Number_____

If responsible party is someone other than the patient, please complete section below:

Responsible Party_____Relationship to Patient_____

Home Phone Number _____ Cell Phone No_____Driver's License #_____

SS # _____Email Address_____

Home Address _____Work Phone_____

Employer's Name_____Employer's Phone_____

_____I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED WIIL BE IMMEDIATLY DUE AND PAYABLE.

_____I CLEARLY UNDERSTAND AND AGREE AS THE PARENT / GUARDIAN THAT ALL SERVICES RENDERED TO THE **MINOR/PATIENT** WILL BE CHARGE DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR ANY PAYMENT DUE. I ALSO UNDERSTAND IF THE **MINOR/PATIENT** SUSPENDS OR TERMINATES THE CARE AND TREATMENT, ANY FEE FOR PROFESSIONAL SERVICES RENDERED WILL BE IMMEDIATELY DUE AND PAYABLE.

Patient's Signature_____

Parent/Guardian's Name_____ Parent/Guardian's Signature_____