Patient Information:

Name: ______________________________________ DOB: _________________________

Age: _______ Sex: _______ Marital Status: ___________ Occupation/Grade: ______________

Allergies to Medication (if know): ____

Home Address: ____

City: ____ State: _________ Zip: ___________

Home Phone: _________________________ Work/Cell Phone: _______________________

Social Security Number: ___________________ Driver's Lic. No: _____________________

Referred by: ____

Responsible Person (If patient is a minor):

Name: _____________________________________ Relation: _______________________

Address (if different from above):____

City: ____ State: _________ Zip: ___________

Home Phone: _________________________ Work/Cell Phone: _______________________

Billing Information:

Credit Card #: ________________________________ Visa, MasterCard, Discover (circle one)

Name on Card: ____

CV Code (back of card): ______________ Exp: ______________

Address of Card: ____

Charges are due upon services rendered. I understand that I am financially responsible for the charges incurred for treatment including those not covered by my insurance plan(s), and that charge is made for time reserved unless full 24 hours advanced notice is received. My signature below also provides credit card authorization if this information is listed above.

Patient Name (Guardian if minor): ____

Signature: ____ Date: _________________

Witness: ____ Date: __________________

1849 Sawtelle Boulevard, Suite 543, Los Angeles, CA 90025
Tel: 310-268-1888 * Fax: 310-268-1880 * Email: info@RenewedFreedomCenter.com
www.RenewedFreedomCenter.com