ASPIRE
WELLNESS

CLIENT INFORMATION

Date _____ Name _____ Date of Birth _____

Patient Home Address _____ City_____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Work Phone #:_____ E-mail Address _____

Responsible Party name _____ DOB _____ Relationship _____

Address _____ City_____ State_____ Zip_____

Home Phone # _____ Cell Phone # _____

Emergency Contact Name _____ Phone # _____ Relationship_____

You may contact me regarding my appointments by:

Voice mail message at _____ E-mail _____

Sensitive/confidential medical information regarding my care may be handled as follows:

___You may leave voice mail messages at the following number(s): _____

___You may e-mail me at the following e-mail address: _____

I understand that payment is due at the time of the service, including all co-pays, self-pay fees and outstanding balances.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature Date