DuPont Associates, P.A.
PATIENT INFORMATION SHEET

PLEASE PRINT-

Patient Name: ____ Date: ________________
Last First Middle

Birth date: __________________________ Sex: M____ F____

Address: ____

____

Home Phone #: __________________________ Ok to leave messages ? Yes______ No ______

Work Phone #: __________________________ Ok to leave messages ? Yes______ No ______

Cell Phone #: __________________________ Ok to leave messages ? Yes______ No______

Email: ________________________________

Eligible for Medicare? Yes_____ No_____ Person who referred you:______________________

(If a physician, please note telephone number with area code). ___________________________

Person Responsible for payment (if different from above):_____________________________

Relationship to patient: ____

Address: ____

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Home Phone #:__________________________ Work Phone #:___________________________

Cell Phone #:__________________________ Other Phone #: ____________________________

Payment for each session is to be made at the time of the session, with checks made out to: ***DuPont Associates, P.A.*** *and given to your doctor or therapist. Statements showing payments and charges, diagnosis and practitioner identification will be given to you at every appointment. These statements can be used for insurance purposes. Appointments not canceled at least one full working day (24 hours) prior to session will be charged to the patient.*

DuPont Associates, P.A. does not provide emergency care. In the event of an emergency, you should call your physician or proceed to the nearest emergency room.

I HAVE READ AND AGREED TO THIS POLICY:

______________________________ ____

Patient Signature Person Responsible for Payment signature (if applicable)

(For Office Use Only) DX Code: _________________________

January 2017