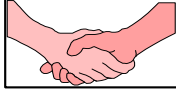


Welcome



Dr. Charles E. Fankhauser

Date _____

PATIENT INFORMATION

Name _____ Male / Female Birthday: _____

Address: _____ City: _____ State _____ Zip: _____

Circle: Minor Single Married Divorced Separated Widowed Other

Phone: Home: _____ Work: _____ Cell: _____

If Student, Name of School _____ City: _____ State _____

Circle: Full Time Student Part Time Student

Employer _____ Position _____

Address: _____ City: _____ State _____ Zip: _____

Spouse Name _____ Employer _____ Phone _____

Whom May We Thank for Referring You? _____

Person To Contact In Case of Emergency? _____ Phone _____

Relationship to patient _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN _____ Date Employed _____

Name of Employer _____ Union/Local # _____ Work # _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group _____ ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANOTHER INSURANCE? YES / NO IF, YES PLEASE COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN _____ Date Employed _____

Name of Employer _____ Union/Local # _____ Work # _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group _____ ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

The information that I have given today is correct and true to the best of my knowledge.

I understand that a \$40.00 charge will be added for missed appointments, and appointments cancelled less than 24 hours in advance.

Patient signature _____ Date _____