PRAIRIE SPA

Date:_____/_____/_____

PATIENT INFORMATION

ALLERGIES:

LAST NAME:_____ **FIRST NAME**:_____ **MI**:_____ **SSN**:
_____

MARITAL STATUS (please circle): Single/Mar/Div/Sep/Wid ( ) Male ( ) Female **ETHNICITY/RACE**:
_____

DATE OF BIRTH: _____/_____/_____ **AGE**: _____ **STREET ADDRESS**:
_____

CITY:_____ **STATE**:_____ **ZIP CODE**:_____

EMAIL:_____ **HOME PHONE**: ( )-_____-_____ **CELL PHONE**:
( )-_____-_____

OCCUPATION:_____ **EMPLOYER**:_____**EMPLOYER PHONE**:
( )-_____-_____

REFFERED TO PRAIRIE SPA BY (please check one):

-
- DR._____
- Facebook
- Radio Ad
- Family/Friend
- Close to home/work
- Yellow Pages

- Other_____

IN CASE OF EMERGENCY:

Name of local friend or relative (not living at same address):
_____

Relationship to patient:_____ **PHONE**: ( )-_____-_____ **WORK PHONE**: ( )-_____-_____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I AM FINANICALLY RESPONSIBLE FOR ANY BALANCE.

_____
_____

PATIENT/GUARDIAN SIGNATURE **DATE**