Date:

PATIENT INFORMATION (Please use full legal name)

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: _____ Marital Status:_____

Address: _____

City:_____ State:_____ Zip Code: _____

Home Phone: (_____)_____ - _____ Cell Phone: (_____)_____ - _____

E-mail Address: _____ Social Security Number: _____

Employer / School: _____Occupation: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone: (_____)_____ - _____

SPOUSE INFORMATION

Last Name: _____ First Name: _____Middle Initial: _____

Date of Birth: _____/_____/_____ Age: _____

Employer:_____ Occupation: _____

Address:_____

City: _____ State: _____ Zip Code:_____

Business Phone: (_____)_____ - _____ Cell Phone: (_____)_____ - _____

EMERGENCY CONTACT INFORMATION (if other than Spouse)

Name:_____ Relationship to Patient: _____

Phone Number: (_____)_____ - _____

How did you learn about our practice? _____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance prior to rendered services. I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Mike Gonce, M.D. representatives to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, instruction or care related to my procedure/s, and any other medical information pertaining to me. I understand that I have the right to rescind this authorization at any time by notifying Mike E. Gonce, M.D. in writing. LAB/X-RAY/DIAGNOSTIC SERVICES: I understand that I may be informed to receive tests prior, during, and/or after treatment and will be financially responsible for any co-pay, insurance, or private pay fees pertaining to such testing.

PATIENT SIGNATURE: _____ **DATE:** _____