CLIENT REGISTRATION

Name:____Date:__________________________
Last First MI

Address:____
Street City State Zip Code

Home Phone:__________________________Work Phone:______________________Cell Phone:____________________

Contact Preference: O Home O Work O Cell E-mail Address:_________________________________

Sex: O Female O Male Date of Birth:____________________________________Age:_______________

Primary Care Physician:____

Emergency Contact:____________________________Relationship:_______________________Phone:_______________

I verify that the above information is accurate to the best of my knowledge and that I have received and reviewed a copy of the Notice of Privacy Practices.

Signature:____

Please tell us how you learned of our service or whom we can thank:

O I was a former patient/client O Former Patient/Client Recommendation (Name:_____________________________)

O Yellow pages O Family/Friend/Co-worker recommendation (Name:___________________________)

O Facility Sign O Doctor recommendation (Name:____)

O Website/Internet O Saw you at an event (Event:____)

O Newspaper article O Health Club/Local Business (Name:____)