Thank you for choosing our office!

In order to serve you properly, we will need the following information. Please print.

Patient name: Last ____________________ First ____________________ M __________

Mailing address: ____

City / State: ______________________________ Zip code: ________________

E-Mail address: ____

Please check: ❒ Male ❒ Female | ❒ Employed ❒ Retired ❒ Student

Patient's employer / School name: ____

Home phone #: ________________________ Cell phone #: ________________________

Work phone# ________________________

Date of birth: ________________________ Social Security #: ________________________

Please check: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Other

Spouse name / Parent name: ____

Person financially responsible for this account: ______________________________

Emergency contact name: ________________________ Their phone #: ________________

What pharmacy do you use?____

I authorize this office to release any information necessary to expedite insurance claims.
I also authorize treatment by Lewis Tondo M.D.

***Signature: ______________________________ Date: ____________________
(Patient/Parent/Legal Guardian)