Appt. Date:_____ Pract._____
Account #_____ Staff Int._____

Welcome and Thank You for choosing KIEPbalance

Patient In-Take Form

Personal

Patient Name: Date:

Address:

City/State/Zip:

Social Security #:

Driver's License #:

Gender: M F Status: M S W D

Spouse's Name: # of kids:

Patient's Birth date: Age:

Home Phone: Cell:

Work Phone: Ext.:

**E-mail:

Emergency Contact:

Emergency Phone: Relation:

Family Doctor:

May we ask how you were referred?

Employment

Employer:

Address: Occupation:

City/State/Zip:

Case

Were you in an auto accident?

Were you in a work related injury? Injury Date:

Is this a legal claim related injury? Injury Date:

I clearly understand & agree that all services rendered to me are charged directly to me & that I am personally responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for treatment rendered to me will be immediately due and payble.

Patient's Signature: _____Date:_____ _____