

## Dr. Quinn Weight Loss- Patient Information Form

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Name you prefer to be called: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cellular: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Driver's License Number \_\_\_\_\_

### **Employment Information:**

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work phone No: \_\_\_\_\_ Ext. \_\_\_\_\_

### **In Case of Emergency:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

### **Financial Policy:**

Thank you for selecting Dr. Christopher Quinn, D.O. of Dr. Quinn Weight Loss for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, American Express, and cash. ALL SERVICES ARE NON-REFUNDABLE.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date