

## New Client Registration

Client's Full Name: \_\_\_\_\_

Gender: *Male* *Female* Date of Birth: \_\_\_\_\_

If you are the client's parent or legal guardian, please indicate the following:

Your Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Other Parent  
Or Guardian's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Phone Numbers:

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

How Would You Prefer To Be Contacted? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Their Phone(S): \_\_\_\_\_

Name of Physician or Clinic: \_\_\_\_\_ Approx. Date Of Last Visit: \_\_\_\_\_

How Did You Hear About My Practice? \_\_\_\_\_