Patient Surname, ________________________ First Name, ______________________ Middle Initial, ____

Age, _______ Date of Birth, ______/______/______

Address, ______________________________________ PostalCode,___________Country, ____________

Phone Numbers

Business ( ) _____________________ Home ( ) _____________________

Mobile ( ) _____________________ Fax ( ) _____________________

E- mail _________________________@_____________

Person responsible for payment

Surname, ____________________________ First Name, ______________________ Middle Initial, _______

Address, ____ Postal Code,________________

Country, ________________________

Who referred you? ____

General Practitioner __________________________________ Phone ( ) ___________________

Address, ____

____ Postal Code, _________________

Country, __________________________

Whom may we contact in the event of an emergency?

Surname, _____________________, First name, _________________, Middle Initial, ______Phone _________

Address, ____ Postal Code, __________________

Payment at time of service cash, check or credit card.
I authorize Dr. ___________________ to disclose complete information concerning medical findings and treatment of the undersigned, from the initial office consultation until the date of conclusion of such treatment, to those individuals who, in Dr. ____________________________ sole determination are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.
A photocopy of this assignment is to be considered as valid as an original

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Patient's Signature Date

____

Parent's or Guardian's Signature (if patient is under 16 years of age) Date