

Patient Data: The Healing Arts Center

Date: _____

Title: Mr. Mrs. Ms Miss (check one) **Referred By:** _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address : _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Date of Birth: ____/____/____ **Sex:** Male Female **Email:** _____

Social Security Number: _____ - _____ - _____ **Marital Status:** Single Married Other

Employment Status: Employed Full Time Student Part Time Student Other (check one)

Spouse Data

Is your spouse a patient in the clinic? Yes No **Spouse's Birthdate:** _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Employer Data (If applicable)

Name: _____

Address : _____ **Phone Number:** _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact

Contact Name: _____

Contact Phone: (_____) _____ - _____