PATIENT INFORMATION

Date

Name

Last | First | Mid Initial

Address | City | State | Zip

Home Phone | Cell Phone

Social Security No. | Date of Birth | Age

Spouse/Partner's Name | Children's Ages

Occupation | Employer/School

Email | Work Phone | Ext.

PCP - Primary Care Physician | Phone

Whom may we thank for referring you to our Office?

Examination Policy

This office specializes in the diagnosis and treatment of structural, internal, and nutritional conditions. Evaluation is done to determine the nature and extent of your problem. In addition to our in-office nutritional evaluation, out-of-office laboratory and/or x-ray evaluation may also be recommended, depending on what is necessary in your case. Dr. Ridley will explain what tests are necessary or recommended during your consultation.

Fees are payable at the time services are received. We require 24 hours advance notification of cancellations or changes in appointments, and we reserve the right to charge if sufficient notice is not given.

Patient's Signature ______________________________ Date

Guardian/Parent Signature
authorizing care for minor Children ______________________________ Date