The Downing Clinic - 5715 Bella Rose Blvd. Ste. 100 ~ Clarkston, MI 48348
(248) 625-6677 ~ Fax (248) 625-5633

PATIENT INFORMATION

Please **DO NOT wear scented products or laundry scented fabrics** to the office.
We have staff and patients who are allergic to fragrances.

Complete entire form. Any blank boxes mean we will not be able to courtesy bill your insurance.

Date: _____ Birthdate: _____ Age: _____ Sex: ☐ Female ☐ Male

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Name: _____ _____ _____
Last First Middle Initial

Address: _____ e-mail address: _____

City: _____ State:_____ Zip:_____

Main Phone: _____ Alternate Phone:_____ Work Phone:_____

Place of employment: _____

Address: _____

Spouse or Family Contact: _____Phone:_____

Insurance card holders name: _____ Date of birth:_____

Who can we thank for referring you? _____

Please read and sign:

I understand that The Downing Clinic does not participate in any health insurance plans including Medicare/Medicaid. *Office fees CANNOT be submitted to Medicare/Medicaid for later reimbursement*. I understand and accept responsibility of any and all charges for services, testing, treatment, or office calls that may not be covered by my insurance and expect to pay at the time service is rendered. These charges include, but are not limited to a 'no show' fee of ½ the amount of services scheduled to be rendered, when 48-hour notice of cancellation is not given. I authorize the release of any medical information necessary, including HIV, alcohol abuse, and substance abuse, to process claims for courtesy billing.

Signed:_____ Date:_____
(Patient or Legal Guardian)

Name of Pharmacy:_____ Phone:_____

There are 2 ways to complete this form.
1. Print out this pdf and fill out the information by hand and then bring it with you.
2. Use the form fields that appear in this pdf and type in the information. Be sure to save the form to your computer hard drive for future use. Then print it out, sign with a pen and then bring it with you.