

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

You may print and complete this form by hand or type into this form and save to your computer with your name. You may print the completed form and bring to your appointment or mail, or email to: frontdesk@thedowningclinic.com

PATIENT INFORMATION

Please **DO NOT** wear scented products or clothing with fabric softeners to the office.
We have staff and patients who are sensitive to fragrances.

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: _____