New Patient Information

Welcome to Saving Face, LLC. Thank you for your cooperation in completing these forms. Please read and complete all pages. *Please Print*.

Date	Patient's Name						Home Phone	
Street Address							Work	Extension
City, State, Zip				**Race:**			Cell	
S. S. #		**Marital Status**					Pager	
		S	M	W	D	Sep		
Birth Date	Age	**Sex**					Fax	
		M		F				
Spouse or Parent's Name and Address							Email	
Spouse or Parent's Employer		Spouse or Parent's S. S. N.					Driver's license	State
Spouse or Parent's Employer Address							Spouse or Parent's Work Phone	
Emergency Contact – List 2		Are you a previous patient of Saving Face or PPS? ☐ Yes ☐ No					Spouse or Parent's Occupation	
Name and Address							Name and Address	
Relationship							Relationship	
Home Phone							Home Phone	
Work Phone							Work Phone	

Employment – check appropriate boxes

Occupation		Full Time		Full Time Student		Retired	Injured on the job?		Yes	
		Part Time		Part Time Student		Other:			No	
Patient's or Parent's Employer			Date of Current Illness or Accident:							
Manager's Name			Who to contact at work:							
Employer's Street Address			City, State, Zip							

Referral

Referred by:	**Medical Doctor:**
Name and address of Attorney (If any)	

If greater than 1 year since you updated this form, ☐ Above information correct? Date: _____ Initials of patient or parent: _____
☐ Above information correct? Date: _____ Initials of patient or parent: _____
☐ Above information correct? Date: _____ Initials of patient or parent: _____