



Date _____

Your Name or Client's Name (if a minor): _____

How do you or they like to be called?: _____

Guardian's Name (if patient a minor): _____

Home Address: _____

Date of Birth ____/____/____ Social Security # ____/____/____ Home Telephone Number: _____

Work Telephone Number: _____ Mobile Phone Number: _____

Other numbers: _____ Email address: _____

Work Address: _____

Contact Person: _____ Name/Numbers: _____

Primary Physician: (Name, Specialty, Address/Phone/Fax/email) _____

Consultants/Specialist (Physicians and Non-physicians)

Name	Specialty	Address	Phone/Fax /email
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Pharmacy:

Name	Address	Phone/fax	email
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Permission to send copy of recommendations to other healthcare providers? Yes _____ No _____ Signature _____

Who should we thank for referring you to our practice? _____

How did you hear about the SunRaven? _____

Please read and initial that you have read and understand the following two statements:

1. Michael B. Finkelstein is a licensed medical doctor. The nature of his role at SunRaven is to work with you to explore a holistic approach that will compliment your routine medical care.
We advise you to continue to be followed by your primary care physician and other medical specialists.

Acknowledgement – Initial _____

2. Cancellation Policy/Fee: A cancellation fee of \$200 will be assessed for missed appointments not canceled with more than 72 hours notice. \$100 will be credited towards the fee for the next appointment if scheduled at the time of notification.

Acknowledgement – Initial _____