



Acceptance & Healing LLC

DEMOGRAPHIC FORM

PERSONAL INFORMATION

<i>Title</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Last Name</i>	<i>Ethnicity</i>
<i>Address</i>		<i>City</i>	<i>State</i>	<i>Zip Code</i>
<i>Phone Number</i>			<i>Email Address</i>	
<i>Date of Birth</i>	<i>SSN</i>	<i>Sex</i>	<i>Marital Status</i>	<i>Employed/ Student</i>
<i>Employer/ School Name</i>				<i>Job Title/ Grade</i>
<i>Primary Care Provider</i>		<i>Date of Last Physical</i>	<i>Referred by</i>	

EMERGENCY CONTACT:

By signing this form, I am giving Dr. Van Dermark permission to contact this person in the event of an emergency.

<i>Name</i>	<i>Relationship</i>	<i>Phone Number</i>	<i>Email</i>
-------------	---------------------	---------------------	--------------