The Downing Clinic - 5715 Bella Rose Blvd. Ste. 100 - Clarkston, MI 48348 - (248) 625-6677 Fax (248) 625-5633
E-mail: frontdesk@thedowningclinic.com

PATIENT INFORMATION

APP'T DATE_____ TIME_____

NEW PATIENTS DEPOSIT S_____ DUE WHEN THE APPOINTMENT IS SCHEDULED TO RESERVE THE DATE.

PLEASE NO SCENTED PERSONAL OR LAUNDRY PRODUCT SCENTS TO BE WORN IN OFFICE

(Your appointment may be rescheduled)

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

Marital Status: Married Single Divorced Widowed

Legal 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: _____

Who can we thank for referring you? _____

Please read and sign that you agree and understand these terms:

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 for all charges for services, testing, treatment, or office calls and expect to pay at the time service is rendered. **These charges include but are not limited to a S50 Administration fee when 48-business hour notice of appointment cancellation is not given by New and Established Patients, and IV patients will be charged ½ the cost of the IV made up.** I authorize the release of any medical information necessary, including HIV, alcohol abuse, and substance abuse, for carrying out treatment, payment and health care operations.

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

Name of Pharmacy: _____ Phone: _____