Registration Form

for Sarah A. Steed, L. Ac.

Name:__________________________Email____________________

Street:____

City:_______________________State:_________ Zip:__________

Home phone___________________Cell phone________________

Birth date________________ Age_______

Employer_____________________________

Work phone__________________

Employment Address: _________________________________

In Emergency notify_____________________ Phone___________

Family Physician____________________ Phone_______________

Referred by: ____________________________

I understand that I personally guarantee to be financially responsible to Sarah A. Steed. L. Ac. For all charges and services rendered.

_________________________   _______________

Signature of Patient   **Date**

_____________________________   ___________________

Signature of parent if under 18   **Date**