Personal information

Name: DOB: Sex: M/F

Height: Weight:

Phone: Email Address:

Address, City, State, Zip: (Please email proof of residency to staff@docereclinics.com i.e. utility bill)

Employer:

Current Salary/Hourly Rate:

Part-time/Full-time (Please email a copy of your most recent check stubs for the past 30 days to staff@docereclinics.com)

Other sources of income(you must list all sources of income):

Household size:

Special Circumstances:

Active US Military Status: Y/N (Please email proof of active US Military Status to staff@docereclinics.com)

How did you hear about us?

Emergency Contact

Name: Relationship:

Phone:

Signature: **Date:**

By signing this form, I hereby acknowledge that I have completely read and fully understand the Tithing Program Guidelines. I also affirm the information contained in this application form is correct and truthful. Any misrepresentations could result in a denial of your application. I

acknowledge that I have an affirmative duty to report any changes to my income, residency, or military status.

Patients must also complete the new patient intake form, medical history form and pain questionnaire as well to complete the application process.

To be completed by Docere Clinics Personnel

Approved By:

Date Approved:

Consult Date:

Procedure Date: