Registration Form

for Sarah A. Steed, L. Ac.

Name:____

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:______________E-Mail Address:___________________

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**