

Sheryl M. Hakala, M.D., P.A.

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Welcome to the office of Sheryl M. Hakala, M.D., P.A. Please take a moment to complete the following patient information for: Child Adult

Today's Date: _____ Referred By: _____

Patient Name: _____ Sex: Male Female

Home phone: _____ Cell phone: _____

Date of Birth: ____ - ____ - ____ Age: _____ S.S.#: _____ - _____ - _____

Marital Status: Single Married Other

Employment: Full-Time Part-Time Unemployed F-T Student

Company: _____ City: _____ Work Phone: _____

If student, school attends: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Responsible Party (If different from above):

Name: _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Printed Name: _____ Signature: _____

PLEASE NOTE: PAYMENT IS DUE AT BEGINNING OF EACH SESSION.

PATIENTS ARE RESPONSIBLE FOR THEIR OWN INSURANCE FILING IF APPLICABLE.