

*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.**