Paul F. Trudeau, PhD, PC

Name:	Address:	
Phone (Home)	Mobile	Work
DOB	SS#	
E-mail	Insurance Company	
Employer	Policy#	Group
Spouse/ Partner	Spouse/ Partner Employer	
Referred by	Spouse/ Partner Phone	
Person responsible for payment		
Address	Phone	
Personal Physician		
Nearest relative not living with you		
Phone (Home)	Mobile	Work

Family	**Mother**	**Father**	**Sibling 1**	**Sibling 2**	**Sibling 3**	**Spouse (s)**	**Children**
Name:							
Age/Sex:							
Marital Status/ Years:							
Religion:							
Ethnicity:							
Description							

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Appointments: Please schedule, change, and cancel your appointments through Dr. Paul Trudeau. If you make an appointment and find that you cannot keep it, please notify Dr. Trudeau as soon as possible to avoid charges. Appointments that are missed and not cancelled 24 hours in advance will be charged for the missed appointment.

Payment of Fees: Payment by check, credit card or cash is expected at the time of each visit. Financial responsibility for services rests with the client and family regardless of insurance coverage.

I have read the above and understand the policies concerning appointment scheduling and payment of fees.

Signed____ Date___________________

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