Living Social & Cash Client Intake Form

Balance Health + Wellness
1901 North Clybourn, Suite 301
Chicago, IL 60614

Name: ____

Cell Number: _________________________Home Number: ____________________

Address: ____

City: ____________________________ State: ___________ Zip: ______________

E-mail Address: ____

Sex: M F Age______________________ Birth Date: _________________________

Occupation:____

Patient Employed by: ____

Business Address: ____

Business Phone:____________________________ Fax: ______________________

In Case of Emergency, whom should we contact:

Name: __________________________________ Phone: _____________________

Relationships: ____________________________ Cell: ______________________

Whom may we thank you referring you? ____________________________________

I understand that I am financially responsible for all charges. Furthermore, I understand that payment is due at the time of service and that cancellations made less than 24 hours will be changed the full for service.

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____ ____________________
Responsible Party Signature Date