

PEGGY L. FERGUSON, PH.D.
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405-707-9600

NAME _____ AGE _____
ADDRESS _____
HOME PHONE _____ WORK PHONE _____
CELL PHONE _____ SS# _____ DOB _____
EMAIL _____
EMPLOYER _____ ADDRESS _____
INSURANCE CO. _____
POLICY# _____ GROUP# _____
INSURANCE CO. ADDRESS _____
ID# _____ PERSON INSURED _____
INSURANCE CO. PHONE NUMBERS _____

SUPPLEMENTAL INSURANCE? _____ POLICY # & COMPANY _____

Wedding Anniversary Date _____

I give my permission to release to the following person(s), dates of service, charges, diagnostic impressions, agreement to pay form, and any other information necessary to bill and receive payment for services:

Name of responsible party: _____
Address of responsible party: _____

Client Signature

In case of emergency you may contact the following people:

NAME _____ ADDRESS _____
RELATIONSHIP _____ PHONE (Hm) _____
PHONE (Wk) _____ PHONE (Cell) _____

Client

NAME _____ ADDRESS _____
RELATIONSHIP _____ PHONE (Hm) _____
PHONE (Wk) _____ PHONE (Cell) _____

Client

Witness

Date