Dr. Sharon M. Phillips & Associates, LLC
8050 Beckett Center Drive, Suite 216
West Chester, Ohio 45069
(513) 860-0801

ADULT DEMOGRAPHIC FORM (Rev. 2/12)

Full Name _____ Date of Birth: _____
First Middle Last Age: _____
Gender: M F

Marital Status: _____Single _____Married _____Separated _____Divorced _____Widowed

Address: _____
(Street)(Apartment) (City) (State) (Zip)

Home Phone: _____ Cell: _____ E-mail: _____
*Is it okay to leave a message at home? _____ yes _____ no
*Is it okay to leave a message on your cell? _____ yes _____ no
*Is it okay to use your email address? _____ yes _____no

Employer: _____ Occupation: _____
Work telephone number _____
*Is it okay to leave a message at work? _____ yes _____ no

INSURANCE INFORMATION:

Policy Holder _____ Policy Holder D.O.B. ___/___/___
First Middle Last Policy Holder SS#:_____

Insurance Company: _____ Member ID#: _____

Group #.: _____ Company where Policy Holder works: _____

Policy Holder's Mailing Address (if different from client's): _____
(Street) (Apartment)

_____
(City) (State) (Zip)

Policy Holder's Phone Number (if different from client's): _____

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Client Name: _____ Date of Birth: _____

In order to provide you with a seamless flow of services, we require that you provide us with a credit card that we can use to charge any outstanding balances on your account. You will be notified prior to any charges being made on this credit card.

Cardholder's Name: _____

Type: _____ **MC** _____ **Visa** _____ **Discover**

Number: _____ _____ _____ _____

Expiration Date: _____/_____

Security Code: _____

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR COMPLETE PAYMENT OF SERVICES RENDERED AND I ACCEPT THAT RESPONSIBILITY.

Signature: _____ Date: _____