NEW PATIENT INFORMATION

Dr. Messina & Associates, Inc.
(817) 818-6445
www.drmessina.com
info@drmessina.com

Today's date: ________________

Patient's name: ____ DOB: _______________

Parent's name(s) if Patient is a minor: ____

Home address: ____

____

Home phone: ______________________________ Cell phone: ______________________________

Email: ____

All fees are the responsibility of the Patient. All fees are due and payable at the time services are rendered. I authorize charges to be made on this credit card for the full established rate for each appointment, and each missed appointment not cancelled at least 48 hours in advance.

On file credit card number: ____

Expiration date: ______________ Security/CVV #: ______________

MasterCard: ___ Visa: ___ American Express: ___ Discover: ______

Billing address (if different than above): ____

____

Print name on card: ________________________________ Signature: _______________________________