

**Dr. Lori Rappaport**

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**Patient Information**

Today's date: \_\_\_\_\_

**If patient is an adult, please complete this section. If patient is a child, parent completes this section:**

Your name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License \_\_\_\_\_ Exp: \_\_\_\_\_

Home address: \_\_\_\_\_  
Street

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital status (please circle): S M W D Sep Name of spouse/partner: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_

Email: \_\_\_\_\_

Name of employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred by: \_\_\_\_\_ May we thank them? \_\_\_\_\_

Reason for referral: \_\_\_\_\_

Party responsible for account: \_\_\_\_\_ Relation: \_\_\_\_\_

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**If child is the patient, please provide information below, otherwise skip this section:**

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Parent's names: 1. \_\_\_\_\_ 2. \_\_\_\_\_

Child lives with: Both parents mother father other \_\_\_\_\_

Name of child's school: \_\_\_\_\_ Grade: \_\_\_\_\_

Current teacher (if in elementary school): \_\_\_\_\_ School phone: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

*I agree to accept responsibility for payment at the time of service and for missed appointments or late cancellations (less than 24 hours notice). I am aware that I will be charged for missed appointments and/or late cancellations.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date