

# GORDON RESEARCH INSTITUTE

GARRY F. GORDON, MD, DO, MD(H), PRESIDENT

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## NEW CLIENT SELF-REGISTRATION FORM

Client Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ FAX Number: \_\_\_\_\_

Work Number: \_\_\_\_\_ Data to be FAXED to GRI: \_\_\_\_\_

Additional Data to be FAXED to GRI: \_\_\_\_\_

Current Health Problem/s: \_\_\_\_\_

Past Diagnoses/Health Problem/s: \_\_\_\_\_

Client Question/s for Dr. Gordon: \_\_\_\_\_

### Medical History:

Date of Last Doctor Visit/Examination: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

Physician's Address/Telephone: \_\_\_\_\_

Reason for Examination: \_\_\_\_\_

### Hospitalization History:

Date Admitted: \_\_\_\_\_ Reason: \_\_\_\_\_

Date Admitted: \_\_\_\_\_ Reason: \_\_\_\_\_

Date Admitted: \_\_\_\_\_ Reason: \_\_\_\_\_

Date Admitted: \_\_\_\_\_ Reason: \_\_\_\_\_

## PAYMENT AGREEMENT

The undersigned hereby agrees to all conditions set forth in the New Client Summary, agreeing to pay for services in advance, by (circle one) cash, check or credit card. Credit Card Type: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ CID# \_\_\_\_\_

The undersigned hereby authorizes Garry F. Gordon, MD, DO, MD(H), or any representatives of Gordon Research Institute to bill the above mentioned credit card for payment.

Client Name Printed: \_\_\_\_\_

Client Signature: \_\_\_\_\_