

PATIENT INFORMATION

TODAY'S DATE _____ PURPOSE OF YOUR VISIT _____

Who can we thank for your visit today? Signs() Family() Friend() Newspaper() Other _____

Is this visit the result of a work-related injury? _____ An auto accident? _____

PATIENT DATA

PT IS: MALE () FEMALE () A MINOR<19 () MARRIED () SINGLE () WIDOWED () DIVORCED () OTHER ()

LAST NAME _____ FIRST NAME _____ MI _____

SSN _____ - _____ - _____ SEX _____ DOB ____/____/____ AGE TODAY _____

ADDRESS _____ PHONE (HOME) _____

PO BOX _____ APT # _____ (WORK) _____

CITY _____ STATE _____ ZIP _____ (CELL) _____

EMPLOYER _____ OCCUPATION _____

SCHOOL, IF FULL TIME COLLEGE STUDENT _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE# _____

PARENT or GUARDIAN: Same as Patient Data ()

LAST NAME _____ FIRST NAME _____ MI _____

SSN _____ SEX _____ DOB _____ AGE TODAY _____

ADDRESS _____ PHONE (HOME) _____

PO BOX _____ APT # _____ (WORK) _____

CITY _____ STATE _____ ZIP _____ (CELL) _____

EMPLOYER _____ OCCUPATION _____

NAME AND ADDRESS THAT STATEMENTS SHOULD BE SENT TO:

Same as Patient Data (___)

LAST NAME _____ FIRST NAME _____ MI _____
ADDRESS _____ PHONE (HOME) _____
PO BOX _____ APT # _____ (WORK) _____
CITY _____ STATE _____ ZIP _____ (CELL) _____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY _____ ID# _____ GROUP# _____
NAME OF POLICYHOLDER _____ DATE OF BIRTH _____ SS# _____
EMPLOYER _____

SECONDARY INSURANCE COMPANY _____ ID# _____ GROUP# _____
NAME OF POLICYHOLDER _____ DATE OF BIRTH _____ SS# _____
EMPLOYER _____

ASSIGNMENT AND RELEASE

- 1. I understand that I am financially responsible for charges incurred for services rendered.
- 2. Full payment is expected at the time services are rendered.
- 3. As a courtesy to you, we will submit your medical claim to your insurance company.
- 4. I hereby authorize, and assign, direct payment of my medical insurance benefits to The Wellness Place, P.C.
- 5. I also authorize my medical provider to release any information requested by my medical insurance company.

SIGNATURE of Patient or Legal Representative

DATE Signed

PRINT NAME of Patient

Relationship of Representative to Patient