INTEGRATIVE WELLNESS CLINIC

New Patient Intake Form

Patient Information

Please complete all fields.

Full Name:

Date of Birth (MM/DD/YYYY):

SSN:

Gender:

Address:

City:

State:

Zip Code:

Phone Number:

Email Address:

Emergency Contact Name:

Emergency Contact Phone Number:

Relationship to Emergency Contact:

Employment Information

Employer Name:

Employer Address:

Work Phone:

Occupation:

Insurance and Billing Information

Primary Insurance Provider:

Policy Holder Name:

Policy Number:

Group Number (if applicable):

Insurance Phone Number:

Billing Address (if different from patient):

City:

State:

Zip Code:

Secondary Insurance (if applicable):

Policy Holder Name (Secondary):

Policy Number (Secondary):

Emergency Contact

Name:

Address:

Phone:

Relationship:

Is this visit related to an accident (Y/N)?

If so, indicate what type (auto, worker's comp, etc.):

PATIENT CONSENT

I,_____, give permission to INTEGRATIVE WELLNESS CLINIC Staff to leave messages concerning appointments, referral and test results to (Specify the relationship to you: Spouse, parent, sibling... etc)

Please circle that which applies to you:

I do / do not give permission for the staff to leave medical information (test results I appt. times) on my answering machine provided at the phone numbers given on my patient account information.

**Please be advised that the Medical Staff will not discuss your personal medical information in detail with any family member or friend of the family. **

Signature

By signing below, I confirm that the above information is correct to the best of my knowledge.

Signature: _____

Date: _____