



# Whole Life Health Care – Family Practice

## Confidential Patient Information



First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Sex: M F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security \_\_\_\_-\_\_\_\_-\_\_\_\_

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

Mailing Address \_\_\_\_\_ Apt, Suite or Unit # \_\_\_\_\_

Physical Address (if different than mailing) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Cell/Other (\_\_\_\_) \_\_\_\_\_ Employer \_\_\_\_\_

### If the Patient is a minor, fill in the following:

Parent or Guardian #1: \_\_\_\_\_ Parent or Guardian #2: \_\_\_\_\_

Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

### How did you learn about us? (Please check one)

Word of Mouth (Who?) \_\_\_\_\_  Internet  Newspaper  Yellow Pages

Other (How?) \_\_\_\_\_

**\*\*\*It is the patients responsibility to know the benefits available under their insurance plan prior to receiving care\*\*\***

**\*\*\*PLEASE NOTIFY US OF ANY CHANGES TO YOUR INSURANCE PLAN OR POLICY\*\*\***

### PRIMARY INSURANCE COMPANY

Name of Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Policy Holders DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holders DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holders Sex: M F Policy Holders Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_

### SECONDARY INSURANCE COMPANY

Name of Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Policy Holders DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holders DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holders Sex: M F Policy Holders Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_

### PRIMARY CONTACT FOR BILLING (if patient is under 18)

Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

\* Please review and sign our Financial Policy on next page

This document was created with Win2PDF available at <http://www.win2pdf.com>.  
The unregistered version of Win2PDF is for evaluation or non-commercial use only.  
This page will not be added after purchasing Win2PDF.