

Whole Life Health Care

Patient Information

Name(Last) _____ (First) _____ (MI) _____
Address _____ City _____ State _____ ZipCode _____
Home Phone (_____) _____ Work Phone (_____) _____ Ext. _____
Cell/Other (_____) _____ Employer _____
Sex _____ Date of Birth ____/____/____ Social Security _____ - _____ - _____

If Patient is a minor, fill in the following:

Parent or Guardian #1: _____ Parent or Guardian #2: _____
Relationship _____ Relationship _____
Phone (_____) _____ Phone (_____) _____
Initial if you will allow this minor-patient to be treated at Whole Life Health Care without your presence _____

Emergency Contact _____ Phone (_____) _____
Relationship to Patient _____ Date of Birth ____/____/____

Primary Contact for Billing _____ Phone (_____) _____
Address _____
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?) _____

The following information will be found on your insurance card. We will also need to make a photocopy of your card:

Primary Insurance _____ ID# _____ Group # _____
Insurance is in whose name _____ Employer _____
DOB ____/____/____ Insurance Effective Date _____

Secondary Insurance _____ ID# _____ Group# _____
Insurance is in whose name _____ Employer _____
DOB ____/____/____ Insurance Effective Date _____

Please **read** and **sign** the back of this document.

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