Integrative Health & Wellness Clinic, LLC

General Information and intake form

Name _____ Age_____ Social Security Number _____

Date of Birth _____ Email _____

Address _____ City _____ State _____ Zip code _____

Mailing Address _____ City _____ State _____ Zip code _____

Phone (Home) _____ (cell) _____ (Work) _____

Employer _____

Pharmacy Information

Pharmacy Name _____ Location _____

Emergency Contact

Name _____ Phone _____ Relationship _____

Guarantor Information *(Skip if Patient is Over 18 Years of Age)*

Name _____ Guarantor Date of Birth _____ Guarantor Gender (M/F) _____
Guarantor Social Security Number _____Relationship to Patient _____

Mailing Address *(if different from above)* _____

Home phone _____ Cell phone _____ Work phone _____

Primary Insurance Information

Insurance Company _____ Insurance ID #_____ Group # _____

Name of Subscriber & Address if different from above _____

Subscribers D.O.B. _____ Relationship of patient _____

Secondary Insurance Information

Insurance Company _____ Insurance ID #_____ Group # _____

Name of Subscriber & Address if different from above _____

Subscribers D.O.B. _____ Relationship to patient _____

How did you hear about our practice?

☐ Clinic Website ☐ Newspaper ad (which newspaper) _____ ☐ Social media

☐ Referral from friend ☐Referral from doctor ☐ Other _____