General Information

Patient Name:______________________________DOB:____________________AGE:______________

Address:________________________________City, State, Zip:______________________________

Home Phone:_____________________________Pharmacy :_______________________________

Employer:________________________________Address:_________________________________

Marital Status: S M W D Sex:____________ Social Security #:______________________

Emergency Contact:_______________________Phone Number:__________________________

How did you hear about us?____

Email Address:____

Insurance/Responsible Party Information

Name:____________________________Relationship to Patient:________________________

Address:_________________________City, State, Zip:________________________________

Home Phone:______________________ Other:_____________________________________

Social Security #:__________________DOB:_____________________________________

Employer:_________________________ Address:__________________________________

Insurance Co.______________________ Policy ID:________________________________

Group Number:_____________________Phone Number:____________________________

Secondary Insurance Coverage

Insurance Co:______________________________________ Phone #:____________________

Claims Address:____

Policy #:____ Group #:_________________

Patient Agreement

I certify that the above information is correct to the best of my knowledge and authorize Health and Wellness Clinic to submit claim to the above insurance companies. I also understand that I am financially responsible for all charges whether or not covered by insurance. I also understand that a "no Show" charge will applied for all missed appointments not cancelled or rescheduled 24 hrs prior to the schedule time, and that this charge is not cover by insurance.

By signing this form, I voluntarily give consent to such medical care, treatment and diagnostic test that Dr.Alkhush and his designated associates or assistants believe are necessary.

Signature:__________________Relationship to patient:______________________Date:____________