Holistic Care for Women & Family

PATIENT INFORMATION:	DATE:
Name:	Sex: Age: Date of Birth:
Address:	Is this a worker's compensation case? **YES / NO**
City/State/Zip:	List of Allergies to Medication:
Cell Phone:	List of Current Medications:
Home Phone & Work Phone: H: W:	Marital Status: **SINGLE / MARRIED / DIVORCED / SEPARATED / WIDOWED**
Email:	Name of Spouse:
PARENT INFORAMTION (if client is under 18)	
Name:	Relationship to Client:
Address: (if not the same above)	Date of Birth:
City/State/Zip:	Primary Care Doctors Name/Phone/Fax:
Home Phone:	Would you like HCFWF to share information with your primary care doctor? (circle) **YES NO**
Cell Phone:	If you agree to have HCFWF share health information with other Doctors please see HCFWF staff for a Release of information form.
INSURANCE INFORMATION:	
Insurance Company:	
Primary Carrier's Name:	Primary Carrier's Birth Date:
ID #:	Group #:

In order to submit a claim for a payment to me for services covered under your policy, I must have your authorization to release medical information to your insurance carrier and assign benefits otherwise payable to me to the Doctor or Group indicated on the Claim. I understand that in the event insurance does not cover the expense that I will be responsible for paying the balance in full within 90 days after insurance declines to pay. Late fees and collection costs can be added to my bill.

SIGNATURE: ______________________________________DATE____________________