Getting you back to a happy and peaceful state of mind.

Patient Name: _____ Patient DOB: _____
First Middle Last

Address: _____
Street/PO Box Unit City State ZIP

Email Address: _____

Home Phone: _____ Cell Phone: _____

Gender: Female Male Marital Status: Single Married Divorced Widowed

Emergency Contact Name: _____
First Middle Last

Phone#: _____ Emergency Contact Relationship: _____

Insurance Information

Primary Insurance: _____

Insured's Name: _____

Relationship to Patient: _____ Insured's DOB: _____

Member ID Number: _____ Group Number: _____

Secondary Insurance: _____

Insured's Name: _____

Relationship to Patient: _____ Insured's DOB: _____

Member ID Number: _____ Group Number: _____

Signature of Patient or Responsible Party: _____

Printed Name: _____

Relationship to Patient: _____ Date: _____

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