Date: _______________

Welcome to Capitol Wellness Center! We are incredibly grateful that you found us and are interested in having us join you on your health journey. This form is to get some basic information to get you started. Here at CWC, we do our best to provide detailed information about your coverage or what to expect with our appointments so there are no surprises. We perform a courtesy verification on your insurance to see what you should expect for visits and labs, and if there are any other benefits you can take advantage of. Dr. Breen is booked out for new patients for 6 weeks on average; however, we do have a waiting list and do our best to get patients in as soon as possible. We see patients on Tuesday's, Wednesday's, and Friday's. We also have a few appointment times that are outside of regular business hours or during lunch hours to accommodate as many people as we can. We do require the insurance information is filled out prior to submitting this new patient request form. If you do not have insurance, notate that and we will call to provide cash pay prices.

Patient Name: ____

First Name Middle Initial Last Name

DOB (required): __________________ Preferred 1st name: ________________ Other legal names: _______________

Address: _____________________________________ City: _______________ State:______ Zip:_____________

Email: ____

Phone: Please check box for 1st preference – Appointment reminder will be sent this number:
□ Cell: (___)_________________ □ Home: (_____)_________________ □ Work: (_____)______________________

Confidential voicemail OK? Yes / No SMS/text message OK? Yes / No

What is your birth sex? _________ What gender do you identify as?____________ Pronoun preference:____________

How did you hear about CWC? (Friend, referral, Google, etc.): _________________________________

When are you hoping to book your new patient appointment (ASAP, Tuesday's only, anytime in the afternoon)?

____

11030 SW Capitol Highway Suite 200 Portland, OR 97219
Office: 503.477.7602 | Fax: 971.288.1303
info@capitolwellnesscenter.com | capitolwellnesscenter.com
Partnering with you for whole body health

Insurance Information

Primary
Insurance Company: ___________________________ Group # ___________________

Member ID #_____________________ Subscriber Name (if other than patient): ___________________

Relationship to Subscriber: __________________ DOB: __________

Secondary
Insurance Company: ___________________________ Group # ____________________

Member ID #____________________ Subscriber Name (if other than patient): ___________________

Relationship to Subscriber: __________________ DOB: __________

Check if applicable: □ Auto Accident □ Workers compensation Date of Accident: _________ Claim#:___________

Please prioritize your health concerns:

(1) ____

(2) ____

(3)____

(4)____

(5)____

Please write below any other concerns or priorities for your healthcare that should be addressed during your appointment:

*The information you provide will help to serve and assist reaching your health goals. Your answers are both voluntary and private

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