Aspire Wellness

1738 Gilsinn Lane • Fenton, MO 63026
Phone (636) 594-7883 • Fax (636) 686-6979

New Patient Registration

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____ Gender: _____

Mailing Address:_____

City/State:_____ Zip: _____

Cell Phone: _____ Marital Status: Single / Married / Separated / Divorced / Widowed

Employer: _____ Occupation: _____

Email address: _____ Primary Language: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

How did you hear about us? _____

INSURANCE INFORMATION:

Policy Holder's Name: _____ Employer: _____ DOB: _____

Policy Holder's Relationship to Patient: Self/Parent / Spouse /Other: _____

Primary Insurance Company: _____ ID#: _____ Group#:_____

Secondary Insurance Company: _____ ID#:_____ Group#:_____

EMERGENCY CONTACT:

Name:_____ Phone#:_____ Relationship:_____

Consent to Coordinate Care with Primary Care Physician

Name of Physician: _____ Phone Number: _____

Address: _____ City: _____ State:_____ Zip: _____

Signature of Patient/Guardian: _____ Date: _____

CONSENT AND AUTHORIZATION:

I hereby give my consent and authorization for ASPIRE WELLNESS to use or disclose my personal health information as they see fit. I understand that I have the right to review the provider's privacy notice, to request restrictions and to revoke this consent at any time. This consent and authorization is valid for ASPIRE WELLNESS. I also authorize and request that payment under my insurance programs be made directly to the above provider for any services furnished to me. I understand that even though I have insurance, I am responsible for payment.

Patient/Guardian Signature: _____ Date: _____