



numinosity
a center for wellness

Confidential New Client/Patient Information Form

This is part of your permanent medical record. This information cannot be reproduced or shared without your permission

Today's Date _____

Name _____ Age _____ Date of Birth _____
First MI Last

Home address _____ City _____ State _____ Zip _____

Home phone # _____ Best Number to be reached at: Home Cell Work

Alternate phone # _____ OK to leave messages: Yes No

Social Security Number _____ Email _____

Your present occupation _____ Work phone # _____

Your present employer _____ Employer Address _____

Spouse/Partner's name _____ Phone # _____

Emergency Contact: _____ Phone # _____ Relationship: _____

By initialing here, I give permission to contact the above in case of emergency _____

Person responsible for this account _____ Relationship to patient _____

Phone # _____ Address (if different from above) _____

Whom may we thank for referring you to this office _____

Insurance Information (Courtesy insurance billing is available. Please read our financial policy regarding billing to your health insurance and other payment options.)

Have you verified health insurance coverage for today's services? {circle one} YES NO

If yes, Please answer the following questions to the best of your knowledge

Type of policy: (✓) Group _____ Private _____ Auto _____ Worker's Comp _____

Name of insured _____ Relationship to patient _____

Insurance company name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

MEMBER ID# _____ GROUP or CLAIM # _____ COVERAGE LIMITS _____

CO-PAYMENT _____ Automobile or Worker Comp? Yes/No Date of Injury _____

Client/Patient signature

Date

Revised 04/29/2009