Patient Information Form

Patient Name: (Last)_________________(First)_________________(MI)____
Name you prefer to be called:_______________________________________
Address:____
City:_________________________ State:_________ Zip:______________
Home Phone:______________________ Cell Phone:___________________
Birth Date:__________________ Age:_______
Email Address:____________________ Social Security Number:___________
____

Sex: Male Female Other Choose not to disclose

Marital Status: Single Married Domestic Partnership Divorced Separated Widowed

Employment Status: Full-time Part-time Unemployed Disabled Retired Military

Employment Information

Employer:_____________________________ Occupation:________________
Employer Address:____
City:_________________________ State:_________ Zip:____________
Work Phone:____________________ Ext.:_________

Emergency Contact

Name:____________________ Relationship:___________Phone:_________________
Primary Care Provider:_____________________________Phone:_________________

Pharmacy and Labs

Preferred Pharmacy:______________________________________
Address :____ Phone:___________________
Preferred Lab:____
Address:____ Phone:___________________

Insurance

Primary Insurance:_____________________________________
Secondary Insurance:__________________________________

Please present your insurance card to staff at the front desk

Financial Policy

Thank you for selecting NUTRIHEALTH for your healthcare needs. We are honored to be of service to you and your family. This is to inform you of your billing requirements and our financial policy.

Please be advised that payment for all services will be due at the time of services rendered, unless prior arrangements have been made. We accept most forms of insurance. Please discuss your insurance coverage with a staff member.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

______________________________________ ____________________

Signature **Date**

____

Printed Name

Please present your insurance card to staff at the front desk