Welcome! Please complete the following information -

Patient Information

First Name_____Initial_____Last_____

Date of Birth_____Gender_____Social Security_____Marital Status _____

Primary Phone (_____)_____ Cell Home Work Other

Secondary Phone (_____)_____ Cell Home Work Other

Mail Address_____City_____State_____Zip_____

Email_____Employer_____

Guarantor / Policy Holder Information (if other than patient)

First Name_____Initial_____Last_____

Date of Birth_____Gender_____Social Security_____Marital Status_____

Address_____City_____State_____Zip_____

Insurance Information

Please present insurance card(s)

Primary Insurance Co._____Policy Holder_____

Secondary Insurance Co._____Policy Holder_____

Emergency Contact

Name_____Relationship_____Phone (_____)_____

Release of Information

I authorize my current insurance company/Medicare to pay medical benefits to Healing Arts Community Health Center. I (or my guarantor) agree to pay for any uncovered fees. I authorize the release of medical information necessary to process my medical claims.

Signature:_____ Date:_____

All Patients

I have been provided an opportunity to review the HIPAA Notice of Privacy Practices. Date_____

Patient Signature (Guarantor if patient is a minor): Signature:_____