



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 # _____ OK to leave message: Yes No

Alternate phone # _____ OK to leave message: 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.)*

Please answer the following questions to the best of your knowledge

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

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

Name of insured _____ Relationship to patient _____

Insurance company name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

MEMBER or ID # _____ GROUP or CLAIM # _____

COVERAGE LIMITS _____ CO-PAYMENT _____

Client/Patient signature

Date

Updated 9/2006