OSTEOPATHIC FAMILY WELLNESS CENTER

PATIENT INFORMATION *(Person seeing the Doctor today)*			Preferred method of communication**:**	
Last Name	First Name	Middle Initial	Email Address	
Home Address *(Street, Apt #)*	City		State	Zip
Emergency Contact & Relationship:	**Emergency Contact Phone Number:**			
Home Phone Number	Cell Phone Number		Social Security Number	
Date of Birth	Gender (M-F)	Pharmacy **Name & Location**	Pharmacy **Phone Number:**	
Patient Employer *(Company Name)*	Work Address *(Complete: street, city, state, zip)*		Work Phone Number	
Referring Doctor *(Doctor who referred you to us. If not referred, please write "none" or your Primary Care Physician)*			Patient Marital Status	

BILLING INFORMATION *(Person responsible for any balances not covered by insurance; also called "Guarantor")*		
Name of Person responsible for bill	Home Address *(Complete: street, city, state, zip)*	Home Phone Number

INSURANCE INFORMATION *(Person whose insurance is used for today's Doctor visit; also called "Subscriber")*			
Name of First (Primary) Insurance Company	Address of First (Primary) Insurance Company *(back of ins card)*		Insurance Company Phone Number
Group Number	Policy Number or Insured Person ID Number		Relationship to Patient
Subscriber Name *(Who is the Primary on the plan)*	Subscriber's Home Address *(Complete: street, city, state, zip)*		Subscriber's Home Phone Number
Subscriber Date of Birth *(mandatory)*	Gender (M-F)	Social Security Number	Name of Company where Subscriber works

Name of Second Insurance Company	Address of Second Insurance Company		Insurance Company Phone Number
Group Number	Policy Number or Insured Person ID Number		Relationship to Patient
Subscriber Name *(Policy holder of Insurance)*	Subscriber Home Address *(Complete: street, city, state, zip)*		Subscriber Home Phone Number
Subscriber Date of Birth	Gender (M-F)	Social Security Number	Name of Company where Subscriber works