# VITALIA HOLISTIC HEALTH CENTER - Dr JoAnna Forwell ND

## - PATIENT INFORMATION –

Thank you for choosing our clinic! In order to serve you properly, we need the following information. **PLEASE PRINT.** All information will be confidential.

Name _____ Date _____

Address _____ Gender M/F _____

City _____ State _____ Zip _____

Birth date _____ Email address _____

Home phone _____ Work _____ Cell _____

Who may we thank for referring you? _____

Person (name, number, relationship) to contact in case of emergency _____

_____

**INSURANCE INFORMATION – PRIMARY**

Insurance Company _____

Subscriber I.D. # _____ Group# _____

Name of Insured (if other than pt) _____

Relationship _____ Birth date _____

Name of Employer _____

How much is deductible, if any? _____ What is your copay/coinsurance % if any? _____

RESPONSIBLE PARTY

Name of person responsible for this account (if not yourself) _____

**If you have any additional (i.e. spouse's) insurance, please complete the following.**

Insurance Company _____

Subscriber I.D. # _____ Group# _____

Name of Insured (if other than patient) _____

Relationship _____ Birth date _____

Name of employer (company) _____

How much is deductible, if any? _____ What is your copay/coinsurance % if any? _____

_____

**I authorize the release of any information concerning my (or my child's) health, provided for the purpose of evaluating and administering claims for health insurance. I also hereby authorize payment to insurance benefits otherwise payable to me directly to the Doctor. I understand that I am responsible for any outstanding payments not covered by my insurance company. I understand that if I cancel an appointment with less than a 24 hour notice or if I do not show up for my appointment, a $35 fee will be assessed to my account.**

_____

Signature of patient (or parent if minor) Date