DEMOGRAPHICS

PATIENT INFORMATION:

Name: ____ Date of Birth: _____/____/_____

Preferred Name: _______________________ Age: _________ Gender: M / F Identifies as: M / F

Social Security number: __________________ Do you feel safe in your home? Yes / No

Address: ____
Street City State Zip

Mailing address if different: ____
Street City State Zip

Home phone: _____________ Cell phone: ________________ Email: _______________________

Sign up for our patient portal? Yes No (you will receive an email with the link to set up your access)

Marital Status: ___ Married/Domestic Partner ___ Divorced ___ Single ___ Widowed

Preferred pharmacy (name and location): ____

EMPLOYMENT INFORMATION:

Employed: ___Yes ___No Work phone: _________________ Occupation: ___________________

Employer: ____

Employer address: ____

ADVANCE DIRECTIVE

Do you have an advance directive? ___Yes ___No If yes please provide us with a copy

EMERGENCY CONTACT:

Emergency contact 1: ____ Phone: ______________

Relationship to patient: Spouse/Partner Parent Child Friend/Other

Emergency contact 2: ____ Phone: ______________

Relationship to patient: Spouse/Partner Parent Child Friend/Other

INSURANCE INFORMATION:

Primary Insurance: ____ ID#: __________________
Subscriber name: ___________________________ DOB: ___________ Group #: _____________
Secondary Insurance: ______________________________________ ID#: ___________________
Subscriber name: ___________________________ DOB: ______________ Group #: ___________

Communication/Release of information

Healing Spirit Integrative Health Center has my authorization to:

Leave appointment reminders on my home / cell / work voice mail	Yes	No
Leave medical information on my home / cell / work voice mail	Yes	No
Contact me at my place of employment	Yes	No

I authorize Healing Spirit Integrative Health Center to discuss any information regarding my care with below mentioned person(s):

Name: _________________________________ Phone #: _____________________

Relationship to patient: Spouse/Partner Parent Child Friend/Other

Name: _________________________________ Phone #: _____________________

Relationship to patient: Spouse/Partner Parent Child Friend/Other

This release of information is valid until revoked in writing by the patient.

I certify that the information provided is accurate and complete to the best of my knowledge. I will not hold the staff at Healing Spirit responsible for any errors or omissions that may have been made in the completion of this form. If I am entitled to insurance benefits, I assign all benefits payable to Healing Spirit Integrative Health Center. I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to pursue collections or legal actions for any amount, I agree to pay all costs and expenses including, but not limited to attorney fees. I hereby authorize the clinical staff at Healing Spirit to administer treatment as deemed necessary. I acknowledge that the services I receive at Healing Spirit Integrative Health Center are provided and/or supervised by nurse practitioners.

____ ______________
Signature of patient/responsible party Date

____
Printed name of responsible party