



Date: _____

Name: _____
First Middle Last Maiden

I prefer to be called: _____ Date of birth: _____

Address: _____
Street City State Zip

Home Phone #: _____ Work #: _____ Cell Phone : _____

Perferred Contact # : _____

Email address: _____

Male ___ Female ___ Marital Status: _____ Social Security #: _____

Ethnicity: ___ not Hispanic or ___ Hispanic Language: _____

Race: ___ White; ___ African American; ___ American Indian or Alaska Native;
___ Asian; ___ Native Hawaiian or ___ Other

Employer Name & Address: _____

Job Title or Description: _____

Person responsible for account: _____

Insurance Carrier:

Name: _____ SSN # _____
First Middle Last

Address: _____ Date of Birth _____
Street City State Zip

Home phone #: _____ Relationship to patient: _____

Employer Name & Address: _____

Work #: _____ Other #: _____

Authorization for Medical Information

I authorize information about my visits and account to be released to:

Mother-Name _____
Father-Name _____
Spouse/Partner _____
Other-Name _____

I authorize that my results and information may be left:

On my answering machine/voice mail _____
On my voice mail at work _____
On my cell phone's voice mail # _____
Other _____

Pharmacy number: _____

Emergency Contact Information:

Name: _____ **Relationship:** _____

Home phone #: _____ **Work #:** _____

Other #: _____

The patient (parent/guardian) is responsible for all fees, regardless of insurance coverage. This includes, but is not limited to, co-insurance, co-payment, deductible, and non-covered services.

I hereby authorize Nourish Wellness, LLC to furnish insurance companies or their representative's information concerning my (my dependent's) illness and treatments. I hereby assign to Nourish Wellness, LLC all payments for medical services rendered to myself (or dependent). I understand I am responsible for any amount not covered by insurance. I agree that should this account become delinquent I am responsible for any attorney fees and other costs of collection.

Signature of Patient

Date: _____

Signature of Parent or Guardian

Date: _____