



## PATIENT INFORMATION

Date: \_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
(Last) (First) (Middle)

Preferred Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_ Prefix: \_\_\_\_\_ Suffix: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Female  Male Social Security #: \_\_\_\_\_

Race:  Am Indian/Alaskan Native  Asian Ethnicity:  Hispanic/Latino Primary Language:  English  
 Black/African American  White  Non-Hispanic/Latino  Spanish  
 Nat Hawaiian/Pacific Islander  Declined Other: \_\_\_\_\_  
 Declined  Other

Marital Status: \_\_\_\_\_ Driver's License: \_\_\_\_\_ Religion: \_\_\_\_\_

Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_ Primary:  Home  Work  
 Cell

Fax: \_\_\_\_\_ Pager: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred Communication Method:  Email/Patient Portal  Mail  Phone-Cell  Phone-Home  Phone-Work

## EMERGENCY CONTACT

Please list closest relatives/friends, preferably not living at same address

Emergency Contact 1: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Emergency Contact 2: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## EMPLOYER INFORMATION

Employer: \_\_\_\_\_ Employment Status:  Full time  Part Time

Occupation: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Responsible Party Name: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Female  Male Social Security #: \_\_\_\_\_

## PRIMARY INSURANCE

Insurance Company Name: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Policy ID: \_\_\_\_\_ Group Name/Number: \_\_\_\_\_

Subscriber/Policy Holder Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Subscriber Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_ Copay: \$ \_\_\_\_\_

## SECONDARY INSURANCE (If applicable)

Insurance Company Name: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Policy ID: \_\_\_\_\_ Group Name/Number: \_\_\_\_\_

Subscriber/Policy Holder Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Subscriber Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_ Copay: \$ \_\_\_\_\_

## AUTHORIZATION FOR ACCOUNT ACCESS

Please list any individuals that you authorize Healthy Habits Wellness Center representatives to speak with regarding questions relating to your bill or statement, including your account information, insurance information, charges and payments.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION AND CONSENT (Please initial each line item and sign and date below)**

\_\_\_\_\_ I authorize the providers/physicians at Healthy Habits Wellness Center to render treatment deemed necessary in his/her professional opinion. I will make every effort to comply with the recommended course of treatment.

\_\_\_\_\_ I understand that payment is due at the time service is rendered. I understand that copays are due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any provider/physician involved in my medical care. I realize the authorization allows Healthy Habits Wellness Center, Inc., to release any information to any of my insurers or providers/physicians. I authorize Healthy Habits Wellness Center access to view my pharmacy benefits when available from my insurance company.

\_\_\_\_\_ I authorize and direct my insurers to pay directly to Healthy Habits Wellness Center, Inc., and/or its physicians/providers any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to Healthy Habits Wellness Center Inc., including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to Healthy Habits Wellness Center, Inc., and/or its affiliates, including its providers/physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable fees in the event this account is turned over for collections. I authorize Healthy Habits Wellness Center, Inc., to contact me on any phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I understand that I am financially responsible to Healthy Habits Wellness Center for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or will establish an agreeable payment arrangement with the Office Manager.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party Signature (if different than patient)