Patient Information

Welcome! Thank you for selecting our practice. In order to serve you properly, we will need the following information. All information will be kept strictly confidential. (Please print clearly)

Patient Name_____
StreetAddress_____
City _____ State_____ Zip/Postal Code_____
Phone: (Home)_____ (Cell)_____
(Fax)_____
Email_____
Date of Birth_____ (M/D/YR) (Circle) Male / Female
Marital Status: (circle) Single Married Divorced Separated Widowed Partner

If Child,
Parent/ Guardian's Name_____

Employer _____
Occupation_____
Address_____Phone_____
Referring Physician_____ Family Physician_____
Address_____ Address_____
Phone _____ Phone _____

Insurance Carrier(s)_____
Phone_____

In Case of emergency, please provide us with the name of the nearest relative not residing with you: Name_____
Phone_____
Relationship_____

I understand that payment is expected on the day of each treatment, with the exception of Worker's Compensation insurance coverage. I am responsible for all charges, regardless of insurance coverage. I understand that Body Wellness is not a Medicaid or Medicare Provider and therefore cannot submit payment for reimbursement. I understand that Body Wellness expects prompt payment of all bills for services rendered. I am responsible for prompt payment for all such bills.

Patient/ Guardian Signature_____
Date_____

Body Wellness
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