Healthcare Wellness Center

(631) 665-1666

260 W. Main Street, Suite 13- Bay Shore, NY- 11706

PATIENT INFORMATION:

Last Name: _____First Name: _____MI:_____

Address: _____Apt#_____

City: _____State:_____Zip:_____

Home Phone: _____Work Phone: _____

Cell Phone: _____

M/F Date of Birth: _____Age:_____Marital Status: _____

Employer Name: _____Occupation:_____

Employer's Address: _____

Primary Physician: _____

Referred By: _____

- Email Address for Appointment Confirmations:_____

SPOUSE OR GUARDIAN:

Last Name: _____First Name: _____MI:_____

Date of Birth: _____

Work Phone: _____Cell Phone: _____

INSURANCE INFORMATION:

Is this related to an accident? Y □ N □ Date of Accident: _____

Insurance Company: _____

Claims Address: _____

Name of Insured: _____Relationship to Patient: _____

Insured Address if Different From Patient: _____

Insured Date of Birth: _____Insured SS#:_____

ID#:_____Group #:_____

No Fault Claim #:_____No Fault Policy #:_____

Work Compensation Carrier Case #: _____WBC#:_____

Are you represented by an attorney? If so, Attorney Name: _____

Attorney Address: _____

Phone Number: _____

EMERGENCY INFORMATION:

Name and contact information of nearest relative or friend

Last Name: _____First Name: _____

Home Phone: _____Work Phone: _____

Cell Phone: _____Relationship:_____