The Wellness Center & Affiliates
Maria Prendes-Lintel, PhD Kimberley Wands, PhD Megan Watson, PhD

Client Information:

Name: _____ Age: _____ Date of Birth: _____
(last) (first) (mi)

Home Address: _____ Social Security # _____
(street)

_____ Home Phone # _____
(city) (state) (zip) Male _____ Female _____

Referral Source: _____ Ph.# _____
Priority: _____ Routine _____ Urgent _____ Emergent
Reason for Referral: (Note any legal involvement & specifics of any doctor's orders)

_____

_____

Send Bill To:

Name: _____ Relationship to Patient: _____

Address: _____
(street) (city) (state) (zip)

Home Ph.#: _____ Work Ph.#: _____

Employer: _____
(name) (address) (city) (state) (zip)

Insurance/Medicare/Medicaid Information:

Primary: _____ Policy Holder's Name: _____

Address: _____
(street) (city) (state) (zip)

ID/Policy Numbers: _____ Group #: _____

Date of Birth of Insured: _____ Patient Relationship to Policy Holder: _____

Emergency Notification:

Notify in Case of Emergency: _____ Home Ph.#: _____
Work Ph.#: _____
Address: _____

Relationship to Patient: _____

Consent and Payment Authorization:
I hereby authorize the release of any medical information necessary to process Insurance and/or Medicare claims I also accept full responsibility for payment of services rendered.

Patient Signature (if child, parent/guardian) _____Date: _____