

NEWTON WHOLE HEALTH, LLC

PATIENT INFORMATION

Name: _____

First MI Last Preferred

M F DOB: ___/___/___ SSN: ___-___-___ Email Address: _____

Address: _____

Number & Street Apt City State Zip

Preferred Phone: (___) _____ (Home Cell Work) Other Phone: (___) _____ (Type: _____)

Employer & Phone: _____ Occupation: _____

Emergency Contact & Phone: _____ Relationship: _____

Referred By: _____ Primary Care M.D. & Phone: _____

Purpose of Today's Visit: _____

Condition Due to Injury? Yes No If yes what was the cause? Auto Accident Work Injury Slip/Fall Other Injury

Date of Injury? ___/___/___ Describe: _____

Who else have you seen for this condition? _____ What Did They Recommend? _____

Major Surgeries _____ Falls/Accidents _____ Medications _____

Do you exercise/how often? _____ Describe your health? _____

Work Activity: Standing Sitting Bending Squatting Lifting Computer Phone Physical

Do you consume/use... Cigarettes? Yes No How often _____ Alcohol? Yes No How often _____

PRIMARY INSURANCE INFORMATION: Health Auto Insurance Worker's Compensation

Insurance Company: _____ Insurance Phone: ___-___-___

Subscriber Name (if not self): _____ Subscriber Address: _____

Subscriber DOB: ___/___/___ ID/Claim#: _____ Group #: _____

Attorney Name: _____ Atty Address & Phone: _____

Patient's relation to insured: Self Spouse Child Other

SECONDARY INSURANCE INFORMATION: Health Auto Insurance Worker's Compensation

Insurance Company: _____ Insurance Phone: ___-___-___

Insurance Co. Address: _____ Adjuster: _____

Subscriber Name (if not self): _____ Subscriber Address: _____

Subscriber DOB: ___/___/___ ID/Claim#: _____ Group #: _____

Attorney Name: _____ Atty Address & Phone: _____

Patient's relation to insured: Self Spouse Child Other

INSURANCE AGREEMENT

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making a claim from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are directly my responsibility for payment.

I, the undersigned, have insurance coverage and hereby authorize and assign directly to Newton Whole Health, LLC, all medical benefits, if any, otherwise payable to me for professional services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signed: _____ **Date:** ___/___/___