Desert Wellness Center

Family Medicine using Modern Science and Ancient Wisdom

Patient Information Form

Name:____________________________________ DOB:_____________________________________

Address:__________________________________ Home Phone:_______________________________

__________________________________ Cell Phone:_________________________________

Email:____

In the Event of an Emergency, Please Contact:____

Relationship to the Patient:_____________________________ Phone Number:________________________

Insurance Company:____

Group Number:______________________________ Policy Number:_________________________________

Claims Address:____

Insured:_____________________________________ Relation to Patient:__________________________

I acknowledge that I have received a copy of Desert Wellness Center's Notice of Privacy Practices.

____

Patient or legally authorized individual signature Date

____

Printed Name if signed on behalf of the patient Relationship to patient

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