

LifeArts - Integrated Health Center, PC

DEMOGRAPHIC INFORMATION

Date: _____

Last Name: _____ First: _____ M.I.: _____

Address: _____

City: _____ State: _____ Zip + 4: _____

Phone: Home: _____ Cell: _____ Work: _____ (please indicate preferred number)

Email: _____

Preferred appointment reminder method: Email Phone Text (cell phone carrier _____)

Birthdate: _____ Age: _____ Gender: M F Social Security #: _____

Race: American Indian Asian Black Native Hawaiian Other Pacific Islander White Declined/Refused

Ethnicity: Hispanic/Latino Not Hispanic/Latino Declined/Refused

Preferred Language: _____

Marital Status: Single Married Divorced Widowed

Do you have insurance that you would like us to submit claims to? yes no If yes, please provide us with a copy of your most current card. If you receive new cards in the mail, it is your responsibility to provide us with updated copies.

Insured Date of Birth : _____

Emergency Contact Person: _____ Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Spouse's Name: _____

Spouse's Employer & Work Number: _____

How did you hear about our clinic? _____

Who may we thank for referring you? _____

Is this due to a **worker's comp** claim? yes no If yes, does your employer require pre-notification of services? yes no

Name of contact person at work: _____ Phone Number: _____

Name of insurance company: _____ Address: _____ Phone: _____

Do you have an attorney for this claim? yes no

Attorney's name: _____ Phone: _____

Attorney's address: _____

If this is an **automobile accident** claim, please let us know. There are additional forms and information required for automobile accident claims.