LifeArts Integrated Health Center, PC / LifeArts Medical, LLC

DEMOGRAPHIC INFORMATION **Date: _____**

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

Address: _____

City: _____ State: _____ Zip: _____

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

Email: _____

Appointment reminder via text? ☐ Yes please ☐ No

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: _____ Relationship to patient: _____

Insured Address: _____

Insured Employer: _____

Emergency Contact Person: _____ Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____Phone: _____

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 Is this due to an **automobile accident**? ☐yes ☐no

Do you have an attorney for this claim? ☐yes ☐ no

Attorney's name: _____ Phone: _____

Attorney's address: _____

If this is an **automobile accident** claim, we need to have your police report and billing insurance information for the claim.

If this is a worker's comp or automobile accident claim that will be billed to a different insurance, we must have that information prior to starting treatment.

If we do not receive the proper billing/insurance information, you will be responsible for all charges.