**Patient Information for Medical Records** **William F. Corell, MD** **Integrative Medicine Associates**

please print **CONFIDENTIAL**

name _____ _____
first middle last today's date

address _____ _____
street city state zip

birthday _____ age _____ ss # _____ phones/email

married ___ single ___ widowed ___ divorced ___ separated ___ _____ _____
home work

religious preference _____ _____ _____
email cell

List all persons living in your home

| name | age | birth date | relationship | dependent |
|---|---|---|---|---|
| | | | | ☐ yes ☐ no |
| | | | | ☐ yes ☐ no |
| | | | | ☐ yes ☐ no |
| | | | | ☐ yes ☐ no |
| | | | | ☐ yes ☐ no |
| | | | | ☐ yes ☐ no |

patient's employer _____ occupation _____ city & state _____ phone _____

For health-related problems or appointments, may we call you at work? yes ☐ no ☐

spouse's employer _____ occupation _____ city & state _____ phone _____

IN CASE OF EMERGENCY, CONTACT:

_____ _____ _____ _____
(other than household member) relationship home phone work phone cell phone

## I N S U R A N C E

subscriber _____ _____
first middle last home phone

address _____ _____
street city state zip

subscriber's employer _____ occupation _____ city & state _____ phone _____

TYPE OF PAYMENT PLAN - CHECK ALL THAT APPLY

☐ private/self-pay
- ☐ a) no insurance
- ☐ b) insurance co _____

☐ premera bc/bs
subscriber # _____
group # _____

☐ blue cross
subscriber # _____
group # _____

type of coverage:
- office calls ☐ yes ☐ no
- hospital care ☐ yes ☐ no
- lab ☐ yes ☐ no
- prescriptions ☐ yes ☐ no

Who referred you or how did you hear about our practice? _____