HELZER HEALING ARTS CENTER

General Patient Information

First Name ____________________ Last Name ____________________ MI ________
Address ____________________
City ____________________ State __________ Zip ____________________
Date of Birth ____________________ Home # ____________________ Work # ____________________
Social Security # ____________________ Male / Female ____________________
Employer ____________________
Address ____________________
City ____________________ State __________ Zip ____________________
Job Title ____________________
Spouse's Name ____________________

Insurance Carrier ____________________
Address ____________________
City ____________________ State __________ Zip ____________________
Phone # ____________________ Policy/Group# ____________________
Subscriber's Name ____________________
Attorney ____________________
Address ____________________
City ____________________ State __________ Zip ____________________
Phone # ____________________

Date of Accident ____________________ Time __________ AM / PM ____________________
Area of Complaint ____________________

Location & Description of Accident ____________________

Medications ____________________

Surgery History ____________________
In Case of Emergency Contact ____________________
Phone # ____________________
Whom should we thank for your referral? ____________________

I understand and agree that health and accident policies are an agreement between the insurance carrier and me. Furthermore, I understand that Dr. Helzer will prepare any necessary reports and forms to assist me in making collection from my insurance carrier easier, and that any amount authorized to be paid will be paid directly to Helzer Healing Arts Center and will be credited to my account. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

Patient's Signature ____________________ Date ____________________