The Inner Connection
PATIENT INFORMATION AND CONSENT FORM

Personal Information

Date_____

Patient Name_____

Address _____

City_____ State _____ Zip Code _____

Home Phone _____ Sex Male Female

Employer_____Work Phone _____

Date of Birth _____

Social Security Number _____

Insurance Information

Primary Insurance _____

Policy # _____ Group # _____

Insured's Name **if different than above**_____

Relationship to Insured spouse child

Insured's Date of Birth_____Insured's Employer_____

Insured's Social Security Number_____

Secondary Insurance_____

Policy # _____ Group # _____

Relationship to Insured spouse child self

Referred by _____

Reason for visit _____

Is this injury or condition related to work ____ auto ____ Date of injury or illness _____

I, hereby, authorize _The Inner Connection_____ to furnish the insurance company or others not authorized by law, with full information regarding treatment rendered, when so required. I, hereby, authorize my insurance company to pay directly to __The Inner Connection_____ all medical benefits otherwise payable to me and I will be responsible to said doctor for all expenses incidental to treatment rendered not paid under this plan.

Patient _____ Date _____

Responsible Party (if required) _____ Date _____