Balanced Health Center

Patient Name____Date of Birth_______________
Last First MI

Home Address____
Street Town/City State Zip Code

Home Phone ( ) ________________________**Cell Phone** ( )________________________

Email Address______________________________

Employer Name______________________________**Employer Phone** ( )______________Ext. ____

Employer Address____

Primary Care Provider (PCP)____

Address:______________________________________ Phone ( )________________________

You may leave me a message regarding an upcoming appointment at the following number:

Home Phone_______________Cell Phone_________________Work Phone( )__________ Ext_______

You may leave messages regarding test results at the following number:

Home Phone( )________________________ Cell Phone( )________________________

Signature_______________________________________ **Date**____________________

Primary Insurance Information

Policy Holder____________________DOB________

Insurance Company ______________________

ID #______________________________

Group #___________________________

Co-pay:__________

Secondary Insurance Information

Policy Holder__________________DOB_______

Insurance Company ______________________

ID #______________________________

Group #___________________________

I hereby authorize insurance payment directly to Balanced Health Center under my account number otherwise payable to me and authorize BHC to release medical information to my insurer as needed to process claims. I consent to testing and treatment connected to my visits.

Signature______________________________ **Date**_____________

Revised 9/29/2009