

**ARCHER FAMILY WELLNESS CLINIC
DONNA MARIA ARCHER, DC**

PATIENT INFORMATION

Today's Date: _____

Name: _____	DOB: _____ Age: _____ M / F
Address: _____	Social Security#: _____
City _____	Occupation: _____
State / Zip: _____	Employer: _____
Spouse: _____	Empl. Address: _____
Spouse Emp. _____	Single ___ Married ___ Divorced ___ Other ___
Soc. Security # _____	

PHONE NUMBERS

Home Phone: _____	Emergency Contact: _____
Work Phone: _____	Relationship: _____
Cell Phone: _____	Phone: _____
E-mail: _____	Medical Doctor: _____
	Phone: _____

Whom may we thank for referring you (or how did you hear about our office)?

INSURANCE INFORMATION (We will be happy to bill your primary insurance; secondary is your responsibility.)

Primary Insurance	Secondary Insurance
Health Plan: _____	Health Plan: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber ID #: _____	Subscriber ID #: _____
Group #: _____	Group #: _____
Subscriber DOB: _____	Subscriber DOB: _____

CERTIFICATION, ASSIGNMENT AND RELEASE

I certify to the best of my knowledge, the above information is complete & accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered & I agree to notify my provider immediately whenever I have a change in my health condition or health plan coverage. I understand that my provider or a clinical peer employed by my health care plan may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my provider and / or my health care plan to contact my physician, if necessary.

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to my provider (listed above) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Date

