Life in Motion
Family Wellness Center

222 E Virginia Street Evansville, IN 47711
Phone Fax

INSURANCE/PERSONAL INFORMATION

Please submit 2 forms of identification, insurance card and copayment if necessary.

Please complete this form. Write N/a if does not apply. Write "same" if the information requested is the same as the patient.

Do you prefer a nickname? _____

Patient information

First Name _____ MI ____ Last Name _____Date of Birth _____
Address_____
City _____ State _____ Zip Code _____ Social Security # _____
Age _____ Sex _____ Marital Status _____
Home Phone _____ Cell Phone
_____
Occupation _____ Employer _____
Address _____
City _____ State _____ Zip Code _____
Employed Full-time/Part-time/Retired _____

Primary Insurance

Insurance Company _____ Policy Holder Name _____
Holders Address _____
City _____ State _____ Zip Code _____ Social Security # _____
Age _____ Sex _____ Marital Status _____
Home Phone _____ Cell Phone
_____
Occupation _____ Employer _____
Address _____
City _____ State _____ Zip Code _____
Employed Full-time/Part-time/Retired _____
Effective Date of Insurance _____ Insurance ID _____
Group # _____ Group Name _____
Employer Phone # _____Employed Full-time/Part-time/Retired _____

Secondary Insurance

Company _____ Policy Holder Name _____
Holders Address _____

Continue on back

City _____ State _____ Zip Code _____ Social Security # _____
Age _____ Sex _____ Marital Status _____
Home Phone _____ Cell Phone _____
Occupation _____ Employer _____
Address _____
City _____ State _____ Zip Code _____
Effective Date of Insurance _____ Insurance ID _____
Group # _____ _____ Group Name _____
Employer Phone # _____Employed Full-time/Part-time/Retired _____

Tertiary Insurance

Company _____ Policy Holder Name _____
Holders Address _____
City _____ State _____ Zip Code _____ Social Security # _____
Age _____ Sex _____ Marital Status _____
HomePhone _____ Cell Phone _____
Occupation _____ Employer _____
Address _____
City _____ State _____ Zip Code _____
Employed Full-time/Part-time/Retired _____
Effective Date of Insurance _____ Insurance ID _____
Group # _____ Group Name _____
Employer Phone # _____

Spouse/Partner/Guardian Information

Name _____ Relationship _____
Address _____
City _____ State _____ Zip Code _____ Social Security # _____
Age _____ Sex _____ Marital Status _____
HomePhone _____ Cell Phone _____

Emergency Contact

Name _____ Relationship _____
Address _____
City _____ State _____ Zip Code _____ Contact # _____

I acknowledge the information listed above is correct and understand I am financially responsible for all charges completed today. Payments and copayments are due at time of service regardless of insurance coverage.

Signature _____ Date _____