Ashland Integrative Care PC
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PATIENT INFORMATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last Name: First: Middle:			Birthdate: / /	Sex: ❑ M ❑ F ❑ Other
Phone (H): ( ) Phone (Cell): ( )	Patient's Email:	Preferred Communication? (circle one) Phone / Email	Marital Status (circle one) Single / Mar / Div / Sep / Wid	
Street Address:			P.O. Box:	
City:	State:	ZIP Code:	Social Security #:	
Primary Care Physician:			PCP Phone: ( )	
Referred by (please check one box): ❑ Family ❑ Friend ❑ Dr. ______ ❑ Insurance Plan ❑ Hospital ❑ Website ❑ Close to home/work ❑ Other				
Previous Counseling? ❑ Yes ❑ No	Other family members seen here:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Name:	Address:		City, State, Zip:
ID/Policy #:	Group #:		Insurance Phone (MH/SA):
Subscriber's Name:	Subscriber's Soc. Sec. #:	Birth date: / /	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:
Subscriber's Address:			Same address as patient? ❑ Yes ❑ No
Name of Secondary Insurance (if applicable):	Subscriber's name:	ID/Policy #:	Group #:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone no.: ( )	Work Phone no.: ( )

DEMOGRAPHIC INFORMATION			
Highest Grade Completed:	Currently In School? ❑ Yes ❑ No	Veteran? ❑ Yes ❑ No	Tribal Affiliation:

Race: ❑ Alaska Native ❑ American Indian ❑ White ❑ Asian ❑ Black/African/American
❑ Native Hawaiian/Pacific Islander ❑ Other Single Race ❑ 2 or More Unspecified Races

Employment: ❑ Full-Time ❑ Part-Time Occupation: ___________________________ Employer: ______________________
❑ Unemployed ❑ Homemaker ❑ Student ❑ Retired ❑ Disabled (unable to work) ❑ Other

Living Arrangement: ❑ Private Residence ❑ Foster Home ❑ Homeless ❑ Residential Facility
❑ Support Housing ❑ Alcohol/Drug Free Housing ❑ Other

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _Date_

Patient/Guardian name (Please Print)

*Legal guardians – please provide a copy of your legal guardianship documents.