

Integrative Family Wellness Center

16535 W Bluemound Road Suite 222

Brookfield, WI 53005

Please Print

Patient Name _____ Date of Birth _____
Email _____ Male/Female _____
Cell Phone _____ Work _____ Home _____
Address _____ Apartment _____
City _____ State _____ Zip Code _____
Driver's License # _____
Employer _____ Social Security _____
Work Address _____

Spouse _____
Spouse Employer _____ Phone _____
Spouse Birthdate _____ Social Security _____

Primary Insurance _____ CoPay _____
Policy Holder Name _____ Effective Date _____
ID Number _____ Group Number _____
Policy Holder Date of Birth _____ Policy Holders Social Security _____

Secondary Insurance _____
Policy Holder Name _____ Effective Date _____
ID Number _____ Group Number _____
Policy Holder Date of Birth _____ Policy Holders Social Security _____

If Minor or College Student
Responsible Parent _____ Date of Birth _____
Address if different from Parent _____ Phone _____
City _____ State _____ Zip Code _____

Emergency Contact Name _____ Phone _____
Referred By _____
Primary Doctor _____ Phone _____
Pharmacy _____ Phone _____
Allergies or Sensitivities _____
Blood Type _____

How Did You Hear About Us? _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement of this agreement shall be as valid as the original.

Signature _____ Date _____

Date and Initials: _____