# PERSONALIZED WELLNESS INTERNAL MEDICINE INFORMATION SHEET

PATIENT
NAME:____________________________________________________________DOB:______________

ADDRESS:____________________________________________________________________

_______________________________________________________________________________

PHONE NUMBER: ____________________________ CELL NUMBER ____________________

Email: ____________________________________________________________________

_____Yes, I authorize use of my email for communication of office based events or alerts

_____No, I do not authorize use of my email for communication of office based events or alerts.

REFERRAL SOURCE: __________________________________________________________

PRIMARY INSURANCE: ________________________________________________________

Group #:______________________________ Member ID #: ___________________________

Guarantor name:____________________________________________________________

Guarantor address: __________________________________________________________

Guarantor phone:________________________ Guarantor DOB: __________________

SECONDARY INSURANCE: _____________________________________________________

Group #: ______________________________ Member ID #: ___________________________

Guarantor name: ____________________________________________________________

Guarantor address :__________________________________________________________

Guarantor phone: __________________________ Guarantor DOB:_________________________

PRIMARY LOCAL PHARMACY: __________________________________________________

Address: __________________________________________________________________

Phone :____________________________________________________________________