Center for Integrated Medicine
8278-A Bellaire Blvd., Houston, TX 77036
Tel: 713-272-8858 Fax: 713-995-6142

PATIENT INFORMATION Date _____

Name _____ _____ _____ Social Security No _____
(Last Name) (First Name) (Middle Initial)

Address _____ City _____ State _____ Zip Code _____

Phone home _____ work _____ cellular _____

Email (optional) _____

Date of Birth _____ Age _____ Driver's License No. _____ State _____

Sex ☐ Male ☐ Female **Marital Status** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employer _____ Occupation _____

Spouse's name (parent's name, if child) _____

Emergency Contact _____ Relationship _____ Phone # _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Insurance Phone _____

Insurance Address _____

Name of Insured _____ Insured's SSN _____ Insured's DOB _____

Insured's Address _____

Insured's ID No _____ Insured's Group No _____ Insured's Employer _____

Patient's Relationship to the Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Insurance Phone _____

Insurance Address _____

Name of Insured _____ Insured's SSN _____ Insured's DOB _____

Insured's Address _____

Insured's ID No _____ Insured's Group No _____ Insured's Employer _____

Patient's Relationship to the Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

How did you hear about us? ☐ Banner ☐ Newspaper ☐ Radio ☐ Friend ☐ Other

All professional services provided are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient (or parent, if minor patient) is responsible for all fees, regardless of insurance coverage. It is expected that all fees will be paid at the time of services unless other arrangements are made in advance.