



Optimum Health Wellness Center, Inc.
Patient Information

Personal Information (please print)

Date _____

Name: _____

Age: _____ Marital Status: _____

Address: _____

Anniversary Date: _____

Phone: Home _____

Cell _____

City: _____ State: _____ Zip: _____

Employer: _____ Circle: Male Female

Employer Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Retired: __Yes__ No

Date of Birth: _____ Social Security Number: _____

Spouse Information:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: Home _____ Cell _____

Social Security number: _____ Insurance Carrier: _____

Insurance owner's Name: _____ Date of Birth: _____

Insurance owner's Social Security number: _____

Insurance Information: (PLEASE GIVE YOUR CARD TO THE RECEPTIONIST TO MAKE A COPY)

I am financially responsible for any unpaid balance. St. Dominic and several out of state Laboratories are used for testing unless there is a request for another Laboratory.

sign: _____

In Case of an Emergency Please Contact _____ Relationship _____

Address: _____ Phone number: _____

Street&No. City State Zip

Referred By: _____

Address: _____ City: _____ State: _____ Zip: _____