Center for Integrated Medicine

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

PATIENT INFORMATION	IATION Date				
Name	Soci	al Security No			
(Last Name) (First Name	e) (Middle Initial)				
Address		City	State	Zip Code	
Phone home	work		cellular		
Email (optional)					
Date of BirthA	ngeDriver's License 1	No		State	
Sex Male Female M	arital Status Single	Married Sep	parated Divorc	ed Widowed	
Employer	ployerOccupation				
Spouse's name (parent's name, if child	1)				
Emergency Contact	Relationship	P	Phone #		
PRIMARY INSURANCE INFORM	1ATION				
Insurance Company	nce CompanyInsurance Phone				
Insurance Address					
Name of Insured	Insured's SSN		Insured's DO)B	
Insured's Address					
Insured's ID NoIr	nsured's Group No		Insured's Employe	r	
Patient's Relationship to the Insured	Self Spouse Chil	d Other			
SECONDARY INSURANCE INFO Insurance Company Insurance Address					
Name of InsuredInsured's Address)B	
Insured's ID NoIr	nsured's Group No		Insured's Employe	r	
Patient's Relationship to the Insured	Self Spouse Chil	d Other			
How did you hear about us? Bann	ner Newspaper Radio	Friend Oth	her		

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.