



Abundant Life Health Care

The complete balance of health, energy & wellness you can trust.

NEW PATIENT INTAKE:

Date _____

Name: _____ DOB: _____ Female Male

Mailing Address: _____

City: _____ State: _____ Zip: _____

S.S.#: _____ Home # _____ Work # _____ Cell # _____

Occupation: _____ F/T P/T Retired Unemployed

E-mail address: _____

Would you like to receive Karole's e-mail newsletter? YES NO THANK YOU

Emergency Contact: _____ Relationship: _____

Home # _____ Work# _____ Cell # _____

Referred By: _____

Insurance and Payment Information:

| | | |
|---|--|---------------------|
| Responsible Party: | Date of Birth: | Social Security # |
| Address of Responsible Party: | Relationship to Patient: | Phone: |
| City, State, Zip | Employer | |
| Primary Medical Insurance Co: | Secondary Medical Insurance Co: | |
| Member Id # _____ Group # _____ | Member Id # _____ | Group # _____ |
| Subscriber Date of Birth: _____ Relationship: _____ | Subscriber Date of Birth: _____ | Relationship: _____ |

I understand that payment is my responsibility regardless of insurance coverage. I hereby authorize ALHC to furnish insured's insurance company all information, which may be requested concerning my illness or injury. I hereby assign to ALHC all money to which I am entitled for medical expenses related to the services performed from time to time by ALHC, but not to exceed my indebtedness to ALHC. Any money received from such insurance company over and above such indebtedness will be refunded to me when my bill is paid in full.

SIGNATURE OF RESPONSIBLE PARTY: _____

DATE: _____