IMMUNOe HEALTH CENTERS
Excellence in Immune Health

HORIZON PEDIATRICS & PRIMARY CARE

Sinus Solutions AT IMMUNOe

PATIENT INFORMATION (ADULT)

Today's Date: ____ / ____ / ____

Patient Information (please print)

Last Name: _____ First Name: _____ M.I.: _____

DOB: _____ /_____ /_____ SSN: _____-_____-_____ Sex:_____ Marital Status: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____- _____ Ext. _____ Cell Phone: _____-_____-_____

Email: _____ Employer Name: _____ Decline

Race/Ethnicity: _____ ☐ Decline Preferred Language: _____ ☐

Preferred Method of Contact: ☐ Voice Call ☐ Text Message ☐ Email

Next of Kin Info (Name of nearest relative or close friend not living with you, in case of emergency):

Name: _____Home Phone: _____ - _____- _____ Cell Phone: _____ - _____-_____

Physicians Involved With Your Treatment

Physician Name: _____Specialty: _____ Phone: _____ - _____-_____

Physician Name: _____Specialty: _____ Phone: _____ - _____-_____

Primary Physician Name: _____ Do you have a Pharmacy preference? ☐Yes ☐No

Pharmacy Name: _____ Street Name: _____ Phone: _____ - _____-_____

Insurance Information

Primary Health Insurance

Company: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ / _____ / _____

Relation to Patient: ☐ Father ☐ Mother

Other: _____

Policy Holder's Social Sec. #: _____ - _____ - _____

Group #: _____ ID #: _____

Employer: _____

Effective Date: _____ / _____ / _____

Secondary Health Insurance

Company: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____ / _____ / _____

Relation to Patient: ☐ Father ☐ Mother

Other: _____

Policy Holder's Social Sec. #: _____ - _____ - _____

Group #: _____ ID #: _____

Employer: _____

Effective Date: _____ / _____ / _____

I authorize payment of medical benefits to IMMUNOe Health Centers for today's service and all future services. I authorize the release of any medical information necessary to process today's claim and any future claims.

Printed Name: _____ Signature: _____ Date: _____