The Wellness and Prevention Center, LLC
19841 N. 27th Ave Suite 204
Phoenix, Arizona 85027
623-387-3705

Patient Intake Information

PATIENT INFORMATION:

Last name: _____ First name: _____ MI: _____

Street address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Social Security number: _____ Employer name: _____

Employer address: _____

INSURANCE INFORMATION:

Name of primary insured: _____ Date of Birth: _____

Relationship to patient: _____ Social Security number: _____

Street address (if different from patient): _____

City: _____ State: _____ Zip: _____

Responsible party employer: _____ Employer phone: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Primary Insurance: _____ Secondary Insurance: _____

Policy number: _____ Policy number: _____

Group number: _____ Group number: _____

Insurance address: _____ Insurance address: _____

City: _____ State: ___ Zip: _____ City: _____ State: ____ Zip: _____

EMERGENCY CONTACT:

Last name: _____ First name: _____ MI: _____

Relationship to patient: _____ Home phone: _____ work phone: _____

Please complete side 2

Patient Intake Information

LIVING WILL:

Do you have a living will? [ ] Yes [ ] No

Would you like us to have a copy on file in your office chart? [ ] Yes [ ] No

The Wellness and prevention Center LLC (WPC), in alignment with current government requirements is a fully electronic office. This offers us the ability to allow you access to certain components of your medical record via the internet through a secured server. Our electronic medical records (EHR) system is Practice Fusion. Through this system we are able to offer our patients the ability to securely access their medical record, send secure messages to your provider, request medication refills and appointments. Our system will also send you a week and three day notification of pending appointments. In order to access your information through our EHR please provide your email address, this allows us to set up your EHR access. You will not receive any promotions or advertisements associated with this process it is strictly to promote continuity of care to and for our patients. By providing your email address below you are giving WPC permission to set up your EHR internet access and appointment reminders.

Email: _____

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance with _____, and assign directly to The Wellness and Prevention Center, LLC and provider Katrina Spradling, FNP-C all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that by signing this I am agreeing to be seen by the provider, I further understand that I will be included in decisions related to my care, or the care of my child/or loved one of whom I have legal guardianship of. We ask all patients to complete this form once a year and with any changes in address, marital status or family related status.

_____ _____ _____

Responsible Party Signature/Patient Signature Relationship to patient Date

Parents and Guardians in the event your child is not accompanied by you for an appointment. You will need to send a letter stating the date and time of appointment, the child or loved ones name, and the name, and relationship of the person you are giving permission to agree to treatment of your child or loved one. You must include your full name and signature at the bottom with date of signature. Each visit requires a new letter (You can find an example of a permission to treat letter on our website at www.wpcofaz.com on the Patient Portal & Forms page.)

Revised: 12/1/12, 11/10/14
Reviewed: 1/2/13