PHONE: (208) 336-1300 | FAX: (208) 429-1410

3858 N. Garden Way, Suite 202, Boise, ID 83703

Patient Information

Last Name **First Name** **Middle Initial** **Date of Birth**

Address **City** **State** **Zip Code**

Home Phone **Cell Phone** **Work Phone** **Preferred Contact Number**

M_ F__

Social Security Number **Gender** **Email** **Referring Physician/Family Member or Friend**

Guarantor's Information

Guarantor's Name **Social Security Number** **Date of Birth**

Address (If Different than patient) **City** **State** **Zip Code**

Name of Employer/Address **Business Phone**

Primary Insurance Information

Insurance Company Name **Policy Holder Name** **Policy Holder D.O.B.**

Policy Holder Social Security Number **Policy Holder Address (If different from Patient)** **City** **State** **Zip Code**

Relationship to Patient **Policy Number** **Group Number**

Emergency Contact Information

Nearest Relative Not Living With Patient **Relationship to Patient**

Home Phone **Cell Phone** **Work Phone**

*I hereby consent to treatment by all providers at The Well Office, LLC. I hereby authorize this office to treat and release to the above named insurance company any information concerning illness and treatment necessary to expedite insurance payment. I understand that I am ultimately responsible for all charges, regardless of insurance coverage.

Patient/Parent/Guardian Signature: ____**DATE:** ________________________