

**Global Wellness Clinic, P.C.**  
**201 W. 2<sup>nd</sup> St.**  
**Madrid, IA 50156**  
*WELCOME TO OUR OFFICE*

**PATIENT INFORMATION**

Today's Date \_\_\_/\_\_\_/\_\_\_  
Patient's Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_  
Married \_\_\_ Single \_\_\_ Widow \_\_\_ Divorced \_\_\_ Separated \_\_\_ #Children \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Telephone \_\_\_\_\_  
Work Telephone \_\_\_\_\_  
Employed By \_\_\_\_\_  
Occupation \_\_\_\_\_

<b>IF PATIENT IS A MINOR</b> Parent's Name _____ Parent's Home Telephone _____ Parents Work Telephone _____ Parent's Employer _____
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Current Work Status:  Full Time  Part Time  Not Employed  Self Employed  Retired  Military Duty

Spouses Name \_\_\_\_\_ Social Security \_\_\_\_\_  
Occupation \_\_\_\_\_ Employed By \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Telephone \_\_\_\_\_ Referred By \_\_\_\_\_

Is this visit a result of an accident?  YES  NO  
Auto Accident \_\_\_ Work Accident \_\_\_ Other Accident \_\_\_  
Date Injury Occurred \_\_\_\_\_ Symptoms Started \_\_\_\_\_

**INSURANCE INFORMATION**

Policy Holder: Self \_\_\_ Spouse \_\_\_ Father \_\_\_ Mother \_\_\_  
Policyholder's Name \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Secondary Insurance Company \_\_\_\_\_

I have read and understand the financial policy of Global Wellness Clinic, P.C. (GWPC) I understand that my insurance is an arrangement between myself and my insurance company, NOT between GWPC and my insurance company. I request that GWPC prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care prescribed by the doctors at GWPC that fees will be due and payable immediately.

- I have received a copy and understand the Clinic's financial policy and realize that I am financially responsible for all services rendered, including those not covered by my insurance.
- I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.
- I hereby give permission to the doctor to perform general procedures as he may deem necessary in the diagnosis of my condition.

Please check the appropriate box to indicate your method of payment today. \_\_\_ Cash \_\_\_ Check \_\_\_ Credit Card  
I have read and agree to the above statement.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If patient is a minor, parent sign)