Integrative Family Wellness Center

16535 W. Bluemound Rd. Suite 222
Brookfield, WI 53005
P-262-754-4910 F-262-754-4913

Please Print

Patient Name_____Date of Birth _____
Email_____Male/Female_____
Cell Phone_____Work_____Home_____
Address_____Apartment_____
City_____State_____Zip Code_____
Driver's License #_____Social Security #_____
Employer_____
Work Address_____
Spouse_____
Spouse Employer_____Phone_____
Work Address_____
Spouse Birthdate_____Social Security #_____
Primary Insurance_____CoPay_____
Policy Holder Name_____Effective Date_____
ID Number_____Group Number_____
Policy Holder Date of Birth_____Policy Holders Social Security #_____
Secondary Insurance_____
Policy Holder Name_____Effective Date_____
ID Number_____Group Number_____
Policy Holder Date of Birth_____Policy Holders Social Security #_____
If Minor or College Student:
Responsible Parent_____Date of Birth_____
Address if different from Parent_____Phone_____
City_____State_____Zip Code_____
Emergency Contact Name_____Phone_____
Referred By_____
Primary Doctor_____Phone_____
Pharmacy_____Phone_____
Allergies or Sensitivities_____
Blood Type_____
How Did You Hear About Us?_____

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement of this agreement shall be as valid as the original.

Signature_____Date_____

Date and Initials:_____ _____ _____ _____ _____