SMITHTOWN WELLNESS 285 MIDDLE COUNTRY ROAD, SUITE LL-6
SMITHTOWN, NY 11787 631-361-WELL(9355)

Patient's Name: _____

Social Sec # :_____

DOB: _____ Age:_____ Sex: _____ Marital Status: _____

Address:
_____

City: _____ State: _____ Zip: _____

Status: _____ Employed _____F/T Student _____P/T Student

_____ Work at Home

Employer: _____Job Title: _____

Length of Employment: _____

Employer Address:
_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____

Email_____

Is it okay to leave messages?
_____

Immediate Family System (Children / Siblings / Parent / Spouse / Significant Other) and ages:
_____
_____

_____
_____

In Case of Emergency Notify:
_____

Phone: _____
Relationship:_____

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Reason for your visit today:
_____
_____

How were you referred:
_____

Did you ask what your co-pay is? _____ Co-pay Amount: _____

Insurance Company or EAP Name:
_____

Insurance Phone # & Billing Address:
_____

ID # if different from social: _____

Group Number if any:_____

Primary Insured Name _____ Relation to client: _____

Primary Soc. Sec:_____

Primary Insured DOB: _____

Primary Insured's Employer:
_____

Primary Insurance Holder if different from client:

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____

Is the patient covered by a secondary health insurance policy? Y / N If yes, please request an additional form and fill out the same information for the secondary company.

Pediatric Patients: Parent or Guardian, please note what relationship after your signature below.

I affirm the above-mentioned information and that it is correct to the best of my knowledge.

Signature: _____ Date: _____

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