Curative Care Center
Health Care Clinic

CLIENT INFORMATION FORM

DATE:_____/_____/_____

LAST NAME: **FIRST NAME:** **MI:**

DATE OF BIRTH: **SSN: - -** **GENDER:**

STREET ADDRESS: **APT:**

CITY: **STATE:** **ZIP:**

HOME PHONE: **MOBILE:** **OTHER:**

WOULD YOU LIKE TO ENROLL IN THE ONLINE PATIENT/CLIENT PORTAL, THROUGH ATHENA HEALTH ☐ **YES** ☐ **NO**

******IF YES, PLEASE PROVIDE EMAIL ADDRESS:***

CLIENT MEDICAL & PROVIDER INFORMATION *(please print)*

ALLERGIES:

CURRENT MEDICATIONS:

PREFERRED PHARMACY:

PRIMARY MEDICAL PROVIDER:

PRIMARY INSURANCE INFORMATION (IF APPLICABLE):

INSURANCE ID : **GROUP #**

SECONDARY INSURANCE INFORMATION (IF APPLICABLE):

INSURANCE ID : **GROUP #**

HOW DID YOU HEAR ABOUT US? *(please circle all that apply)*

Facebook Google Social Media Flyer Family/Friends Event Outdoor Sign

Website Mailout Word of Mouth Doctor's Office: _____ Other: _____

CLIENT SIGNATURE:_____ TODAY'S DATE: _____/_____/_____