Global Wellness Clinic, P.C.
201 W. 2nd St.
Madrid, IA 50156
(515) 795-3655
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 _____
Cell Telephone _____
E-mail Address _____
Employed By _____
Occupation _____

IF PATIENT IS A MINOR
Parent's Name _____
Parent's Home Telephone _____
Parents Work Telephone _____
Parent's Employer _____

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 INFORMATON

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. (GWCPC) I understand that my insurance is an arrangement between myself and my insurance company, NOT between GWCPC and my insurance company.

- 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 hearby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.
- I hearby give permission to the doctor to perform general procedures as he may deem necessary in the diagnosis and treatment 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)