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 Web: www.IMMUNOe.com

Please fill out all information completely, print clearly, and sign where indicated.

Date ___ / ___ / ___

PATIENT INFORMATION — ADULT

Last _____ First _____ Middle _____ Female Male
 Street _____ City _____ State _____ Zip _____
 Home _____ Cell _____ Work _____
 Date of Birth ___ / ___ / ___ SSN _____ - _____ - _____ Email _____

EMERGENCY CONTACT — Give the name of nearest relative or close friend not living with you, to contact in case of emergency.

Name _____ Relationship _____ State _____
 Home Phone _____ Cell Phone _____ Work Phone _____

OTHER PHYSICIAN — List all physicians involved in your treatment.

Physician's Name _____ Phone _____
 Physician's Name _____ Phone _____
 Physician's Name _____ Phone _____
 Physician's Name _____ Phone _____
 Physician's Name _____ Phone _____

INSURANCE INFORMATION

Primary Physician's Name _____ City _____
 Office Phone _____
 Referred by Self Insurance Other: _____

May we send correspondence letters to your primary care physician? Yes No

Do you have health insurance? Yes No If yes, please fill out the following information:

Primary Health Insurance Information

Insurance Company _____
 Address _____
 City _____ State _____ Zip _____
 Policy Holder _____
 Relation to Patient _____
 Policy Holder's SSN _____
 Group Number _____
 ID Number _____
 Employer _____
 Effective Date _____

Secondary Health Insurance Information

Insurance Company _____
 Address _____
 City _____ State _____ Zip _____
 Policy Holder _____
 Relation to Patient _____
 Policy Holder's SSN _____
 Group Number _____
 ID Number _____
 Employer _____
 Effective Date _____

INSURANCE AUTHORIZATIONS AND ASSIGNMENT

I authorize payment of medical benefits to IMMUNOe Health Centers for these services and all future claims. I authorize the release of any medical information to process this and all future claims.

Signature _____

Date _____