



WELLNESS RESOURCE MEDICAL CLINIC
INSURANCE INFORMATION
30111 NIGUEL ROAD SUITE K
LAGUNA NIGUEL CALIFORNIA 92677
PHONE 949-249-9449 FAX 949-249-4951
WELLNESS-RESOURCE.COM

PATIENT INFORMATION

Date _____ Referred by _____

Name _____

Address _____ Zip: _____

Telephone _____ Email _____

Marital status S ___ M ___ W ___ D ___ Birthdate _____ Age _____ Sex _____

RESPONSIBLE PARTY

Name: _____ Relationship to patient: _____

Telephone number: _____ Social Security Number: _____

Address: _____ Zip _____

Birthdate: _____ Drivers License Number: _____

Employer name: _____ Occupation: _____

Work address: _____ Zip: _____ Work phone: _____

Name of nearest relative not living with you: _____ Telephone: _____

Address: _____ Zip: _____

Primary Insurance Company

Secondary Insurance Company

Name: _____

Name: _____

Address: _____

Address: _____

Group/Policy # _____

Group/Policy # _____

Name of subscriber: _____

Name of subscriber: _____

Relationship to patient: _____

Relationship to patient: _____

Employer name: _____

Employer name: _____

Employer phone: _____

Employer phone: _____

Payment is required at the time of your initial office visit and preferred each time services are performed, unless prior arrangements have been made. Our office will bill your insurance for you. Having insurance is no substitute for payment. It is your responsibility to pay the deductible, co-payment and any other balances not paid for by your insurance. You are responsible for your bill. I also assign and request payment of medical benefits to the providers of the Wellness Resource Medical Clinic and understand that I am financially responsible for any charges not covered by insurance.

Release of Information: I also authorize the release of information of any medical information to process this claim.

Signed: _____ Date: _____