

Integrative Medicine Center

Office of Dr. Steve Windley

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PATIENT INFORMATION FORM

PLEASE PRINT

LAST NAME		FIRST NAME		INITIAL	
MAILING ADDRESS		CITY	ST	ZIP	
		SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
SOCIAL SECURITY NUMBER		EMAIL ADDRESS			
HOME PHONE NUMBER	SECOND PHONE NUMBER	DATE OF BIRTH		RACE	
PLACE OF EMPLOYMENT			EMPLOYERS PHONE NUMBER		
EMPLOYER ADDRESS			CITY, STATE, ZIP		
EMPLOYMENT STATUS: <input type="checkbox"/> F/T <input type="checkbox"/> P/T <input type="checkbox"/> RETIRED <input type="checkbox"/> UNEMPLOYED					
PATIENT OCCUPATION					
<i>IF APPLICABLE:</i> SPOUSE NAME			SPOUSE EMPLOYER		
FAMILY PHYSICIAN			PHYSICIAN PHONE NUMBER		
PERSON TO CONTACT IN CASE OF EMERGENCY			PHONE NUMBER		
RELATIONSHIP TO PATIENT			WHO REFERRED YOU TO OUR OFFICE		
GUARANTOR (person responsible for bill) DOB			GUARANTOR EMPLOYER (IF DIFFERENT)		
PRIMARY INSURANCE		POLICY NUMBER		COVERAGE/GROUP NUMBER	
SUBSCRIBER		RELATIONSHIP TO PATIENT			
SUBSCRIBER SOCIAL SECURITY NUMBER		GROUP NAME			
SECONDARY INSURANCE (<i>currently we are not filing secondary</i>)			POLICY NUMBER		
SUBSCRIBER			RELATIONSHIP TO PATIENT		
SUBSCRIBER SOCIAL SECURITY NUMBER			GROUP NAME		