BodyWise Acupuncture & Total Wellness

885 Canarios Court
Suite #110
Chula Vista, CA 91910
Tel: (619) 656-5102
Fax: (619) 656-5103

955 Lane Avenue
Suite #201
Chula Vista, CA 91914
Tel: (619) 421-9521
Fax: (619) 421-9568

Patient Information

First Name_____ Last Name_____ Gender _____

Address_____Apt #_____City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

SSN#_____-_____-_____ Birth Date_____/_____/_____ Email_____

Relations and Contacts

Person Responsible for Account_____ Phone #_____

Address:_____ Relation to Patient_____

Employer Name_____ Address_____

City_____ State_____ Zip Code_____ Occupation_____

Emergency Contact Name_____Phone #_____Relation to Patient_____

Insurance Carrier Information

Billing Insurance_____ Adjuster (if applicable)_____

Insured Name_____ SSN_____-____-_____ Birth Date_____

Relation to Insured_____ Gender_____

ID# or Claim #_____ Group #_____

Secondary Insurance (if any) _____Insured Name_____

SSN_____-____-_____ Birth Date_____ Relation to Insured_____ Gender_____

ID#_____ Group #_____

Please Read and Sign

I, the undersigned, assign directly to BodyWise Acupuncture & Total Wellness, Inc. all medical insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance, and hereby authorize the practitioner to release and/or obtain medical records as needed for my treatment or to assist in obtaining insurance reimbursement on my behalf.

_____ _____

Patient/Guardian Signature Date