INTEGRATIVE WELLNESS CENTER

DR. HOLLI GOWER, 525 GLEN CREEK RD NW, SUITE 230 SALEM, OR 97304 503-339-7376

PATIENT INFORMATION

ABOUT YOU

NAME: Last_____ First_____ MI_____

Date of Birth:_____ Gender: ( ) M ( ) F SSN:_____

Street Address:_____

City_____ State_____ Zip_____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Email: _____

Employment ( )Employed ( )Student ( )Retired ( )Other

Employer:_____ Occupation:_____

Employer Address: _____

Employer Phone: (____)_____

Marital Status: ( ) Single ( ) Married/Partnered Spouse's Name:_____

Emergency Contact:_____ Phone: (____)_____

INSURANCE INFORMATION

Primary Insurance

Insurance Company:_____ Phone: (____)_____

Claims Address:_____

Subscribers Name:_____ Date of Birth: _____ SSN_____

Subscribers relationship to you: ( ) Self ( ) Spouse ( ) Parent ( ) Other

ID#:_____ Group#:_____

Employer of Insured:_____ Phone: (____)_____

Secondary Insurance

Insurance Company: _____ Phone: (____)_____

Claims Address:_____

Subscriber's Name:_____

ID/Claim#:_____ Policy #:_____

Who may we thank for referring you?_____

(Another Patient?Business?Phone Book?Doctor?)