



NUMINOSITY  
a center for wellness

### Confidential New Client/Patient Information Form

This is part of your permanent medical record. This information cannot be reproduced or shared without your permission

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First MI Last

Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone # \_\_\_\_\_ Best Number to be reached at: Home Cell Work

Alternate phone # \_\_\_\_\_ OK to leave messages: Yes No

Social Security Number \_\_\_\_\_ Email \_\_\_\_\_

Your present occupation \_\_\_\_\_ Work phone # \_\_\_\_\_

Your present employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Spouse/Partner's name \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship: \_\_\_\_\_

**By initialing here, I give permission to contact the above in case of emergency** \_\_\_\_\_

Person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Phone # \_\_\_\_\_ Address (if different from above) \_\_\_\_\_

Whom may we thank for referring you to this office \_\_\_\_\_

**Insurance Information** (Courtesy insurance billing is available. Please read our financial policy regarding billing to your health insurance and other payment options.)

Have you verified health insurance coverage for today's services? {circle one} YES NO

**If yes, Please answer the following questions to the best of your knowledge**

Type of policy: (✓) Group \_\_\_\_\_ Private \_\_\_\_\_ Auto \_\_\_\_\_ Worker's Comp \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insurance company name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

MEMBER ID# \_\_\_\_\_ GROUP or CLAIM # \_\_\_\_\_ COVERAGE LIMITS \_\_\_\_\_

CO-PAYMENT \_\_\_\_\_ Automobile or Worker Comp? Yes/No Date of Injury \_\_\_\_\_

\_\_\_\_\_  
**Client/Patient signature**

\_\_\_\_\_  
**Date**

Revised 04/29/2009

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