Soluna Holistic Healthcare, INC

New Patient Information

Name: _____ **Date of Birth:** _____

Address: _____ **City/Zip:** _____

Main Phone:_____ **Additional Phone:**_____

Email: _____ Permission to add patient portal: **YES/NO** (circle)

Social Security Number: _____

Gender : MALE FEMALE

Martial Status: SINGLE ENGAGED MARRIED SEPERATED DIVORCED WIDOW PARTNER

Race: CAUCASIAN HISPANIC AFRICAN AMERICAN ASIAN AMERICAN INDIAN/ALASKAN PACIFIC ISLANDER REFUSED

Ethnicity: HISPANIC ORIGIN NOT HISPANIC REFUSED

Preferred Language: _____

Preferred Pharmacy: Name_____phone _____

Address_____

Emergency Contact: Name _____ Phone_____

Relationship_____

How did you hear about Soluna? We like to thank our referrals!_____

How can we best contact you for results or returned calls? **Email/Phone** (circle one)

Permission to discuss your medical information or results with?

_____Name _____ Contact information

_____Name _____ Contact information

INSURANCE INFORMATION

Primary Insurance Company:_____

ID#_____ Group# _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to Insured: _____

Secondary Insurance Company:_____

ID#_____ Group # _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to Insured: _____

Insurance Payment/Financial Responsibility Release

I request that payment of authorized Medicare benefits, or any other insurance benefits be made to either me or on my behalf to SOLUNA HOLISTIC HEALTHCARE, INC for any services furnished to me by the Provider. I authorize any holder of medical information concerning me to be released to my insurance carrier or health care financing, its agents, any information needed to determine these benefits or the benefits payable for related services. A photocopy of the authorization shall be considered effective and valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE COMPANY.

SIGNATURE of Patient or legally responsible: _____

DATE: _____