# SOLUNA HOLISTIC HEALTHCARE, INC
# NEW PATIENT INFORMATION

**Name:** _____ **Preferred Name**: _____

**Date of Birth:** _____ **Social Security Number:** _____

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

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

**Email:** _____ Add patient portal: **YES/NO** (circle)

**Permission to text reminder? YES/NO** (circle) **Permission to email reminder? YES/NO** (circle)

**Gender:** _____

**Marital Status:** SINGLE ENGAGED MARRIED SEPERATED DIVORCED WIDOW PARTNER

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

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## INSURANCE INFORMATION

**Primary Insurance Company:**_____

ID#_____ Group# _____

Policy Holder Name: _____

Policy Holder Address: _____

Policy Holder Phone: _____

Date of Birth: _____

Relationship to Insured: _____

**Secondary Insurance Company:**_____

ID#_____ Group # _____

Policy Holder Name: _____

Policy Holder Address: _____

Policy Holder Phone: _____

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:** _____