Pembroke Center for Wellness

Chart#_________________________.

Patient Information

Last Name: ____________________________ **First:** ______________________ **Middle:** _________________

Also Known as/Nickname: _______________________________ **Maiden Name:** ______________________

Address: ____ **City, State, Zip:** ________________________

Home Phone No: _____________________________ **Cell Phone No.** _________________________________

SSN: ___________________________ **DOB:** _________________________ **Sex: Female ~~~ Male**

Race: American Indian ~~Asian ~~ Black ~~ Hispanic ~~ White ~~ Other:________________________

Marital Status: Single ~~~ Married ~~~ Separated ~~~ Divorced ~~~ Widowed Other: ____________

If minor: **Mother's Name:** _____________________________ **Father's Name:** _________________________

And/Or Legal Guardian: ____

Employer: ___________________________ **Work Phone:** _________________ **Occupation:** ______________

Employers Address: _________________________________ **City, State, Zip:** ________________________

Guarantor Information ***(Primary Insurance Carrier for the Client)***

Last Name: ____________________________ **First:** ______________________ **Middle:** _________________

Address: ____ **City, State, Zip:** _________________________

Home Phone: _______________ **SSN:** ________________ **DOB:** _____________ **Relationship:** __________

Employer: ___________________________ **Work Phone:** _________________ **Occupation:** ______________

Employers Address: _________________________________ **City, State, Zip:** ________________________

Emergency Information

Emergency Contact: ____ **Relationship:** ___________

Address: ____ **City, State, Zip:** _________________________

Phone No: ______________________________

Primary Care Physician: ____

Address: ____ **Phone No:** __________________________

List any known allergies/hypersensitivities or drugs you cannot take: ______________________________

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Responsible Party Information ***(Please complete this section if patient is a minor and the guardian filling out this paperwork is different than the Guarantor)***

Last Name: ____________________________ **First:** ______________________ **Middle:** _________________

Address: ____ **City, State, Zip:** _________________________

Phone No: ________________ **SSN:** ________________ **DOB:** _____________ **Relationship:** ____________

Group/Therapeutic Home: ***(If applicable)*** ____

I have completed this document to the best of my knowledge. I agree to inform Pembroke Center for Wellness of any changes that may occur to any of the above information before my next scheduled appointment.

____ ___________________________

Signature of patient or legally responsible person **Today's Date**