Maranatha Natural Living, LLC
Integrative Family Medicine

Patient's Name: _____

Telephone #_____DOB:_____Sex M__F__

Address: _____

_____

Allergies:_____

Social Security #_____

Employer:_____

Primary Insured Name:_____

Primary Insurance:_____

Primary Insurance Address:_____

Primary Policy #:_____Group #:_____

Secondary Insured Name:_____

Secondary Insurance:_____

Secondary Insurance Address:_____

Policy No:_____Group No:_____

EMERGENCY CONTACT:_____

Relationship_____

Telephone:_____

AUTHORIZATIONS

Release of Information: I hereby authorize release of information for insurance purposes. A photostat or facimile copy of the above is as valid as the original.
SIGNATURE OF AUTHORIZED PERSON:_____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Maranatha Natural Living, LLC. I understand that i am financially responsible for those charges not paid by my insurance company.

Signature of Authorized Person:_____