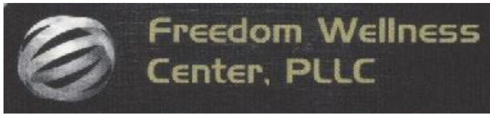

2816 Veach Road, Suite 208, Owensboro, KY 42303
Phone: 270-228-2991 Fax: 270-228-2994

First, M.I. *Last* *DOB* / /

Gender: ☐ Male ☐ Female Social Security Number.: ____________

Status: ☐ Single ☐ Married ☐ Separated ☐ Widow ☐ Other ____________
☐ Dating ☐ LGBT

Client Address: ____________
Street City State Zip

Parent/Guardian/Legal Rep.: ____________
(If applicable) Name Relationship Address Contact No.

Contact Number(s): ____________ ____________ ____________
Home Cell Work/Other

____
Email

Contact preference(s): ☐ Home/Cell ☐ Work ☐ Text ☐ Email ☐ May we leave messages?
Preference(s): ____________

Emergency Contact: Name: ____________ Relationship: ____________
Contact info: ____________

Were you referred? ☐ Yes ☐ No If so, who referred you?: ____________
If not referred, how did you hear about Freedom Wellness Center, PLLC? ____________

Payment Source: ☐ Self ☐ Medicaid/MCO ☐ Priv. Insurance ☐ EAP ☐ Health Savings Acct
☐ Other, please specify: ____________

PRIMARY INSURANCE INFORMATION (complete only if filing for insurance reimbursement):

Policy Holder: ____________
First, M.I. *Last* DOB

Policy Holder ID number: ____________

Policy Holder SSN: ____________ (required to submit claim)

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Copy of medical card and/or insurance card (front/back) **Employer Name:** ____________

SECONDARY INSURANCE INFORMATION (complete only if filing for insurance reimbursement):

Policy Holder: ____________
First, M.I. *Last* DOB

Policy Holder ID number: ____________

Policy Holder SSN: ____________ (required to submit claim)

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Copy of medical card and/or insurance card (front/back) **Employer Name:** ____________

Financial responsbile party: ____________
☐ **Self** Name Relationship

____
Address Contact No.