27023 164th Ave SE, Suite 109 Covington, WA 98042
253-639-7146 Fax: (253) 639-7145 **Email: help@mindsourcecenter.com**

Patient Information - ADULT

PATIENT NAME: _____ BIRTH DATE: _____/_____/_____
FIRST MI LAST

OTHER NAMES USED: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ PARTNERSHIP ☐ WIDOWED ☐ SEPARATED

BEST WAY TO CONTACT: ☐ PHONE ☐ E-MAIL ☐ MAIL GENDER: ☐ FEMALE ☐ MALE

ADDRESS: _____ CITY, STATE, ZIP: _____

HOME #: (_____) _____ WORK PHONE: (_____)_____
PLEASE CIRCLE ► OK TO LEAVE MESSAGE AT THIS # YES / NO ►OK TO LEAVE MESSAGE AT THIS # YES / NO

CELL #: (_____) _____ E-MAIL: _____
►OK TO LEAVE MESSAGE AT THIS # YES / NO

REFERRED BY: _____ PRIMARY CARE PHYSICIAN:_____

EMERGENCY CONTACT: _____PHONE: (_____) _____
NAME RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE NAME:_____ **NAME OF SUBSCRIBER:**_____

ID/SUBSCRIBER#: _____ SSN: _____ DOB:____/_____/_____

GROUP #: _____ EMPLOYER: _____

TELEPHONE # FOR BENEFITS: (_____)_____ **Please note that secondary insurance is not accepted.**

CONSENT TO TREATMENT/RELEASE INFORMATION: I grant MindSource Center, LLC the authorization to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents, to process my payments for service. To the best of my knowledge, all information above is true and correct. I am aware that as a patient I have certain rights and responsibilities and I have been informed of and given access to notice of privacy practices (HIPPA).

PATIENT SIGNATURE: _____ **DATE:** _____

To request this information in an alternative format, please contact Mindsource Center 253-639-7146. We will work with individuals requesting alternate formats, to ensure it is effective. Relay users please dial 711.

Office Use Only CODE(S):