Center for Life Solutions

Client Registration

PATIENT INFORMATION			
Name:			DOB:
Address:			
City:	State:	Zip Code:	Email:
Home Phone:	Work:	Cell:	Best # to reach you at:

Emergency Contact:		Emergency Contact Phone Number:	
Primary Care Physician:		PCP Phone Number:	
How did you hear of us?			

INSURANCE INFORMATON			
Insurance Company:			
Insurance Id #			
Subscriber: **(if different than patient)**			
Subscriber's ID #		Copayment:	
Subscriber's DOB:		Relationship to Patient:	
Secondary Insurance Company:		Secondary Insurance Id #	

Client Name (printed)_____ Client Signature_____ Date:_____

Provider: ____AP_____ _____JP_____ CS_____ LG_____