LiveWell Integrated Health LLC
8026 Hamilton Blvd., P.O Box 96
Trexlertown, PA 18087
610.395.5509

Welcome to LiveWell Integrated Health, LLC!

We are happy you have chosen us for your health care needs.
To serve you as completely as possible, we ask that you complete the following patient information. Thank you for your time and patience in providing this information to us, we realize that you are here because you want to feel better, not because you want to fill out paperwork. We want to help you reach your health care goals, so please be complete with your answers. Thanks!

Patient Information

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: M F Age _____ Birthdate _____

____Single ____Married ____Divorced ____Separated ____Widowed

_____

Occupation _____

Employer _____

Employer address _____

Employer phone _____

Spouse's name _____

Birthdate _____ _____

Occupation _____

Spouse's employer _____

Provide the name/ location of your primary care physician:

_____

Whom may we thank for referring you? _____

Contact Information

Home # _____Work/Cell_____

Email Address_____

Best place / time to reach you _____

IN CASE OF EMERGENCY, CONTACT:
Name _____ Relationship _____
Best # to call _____

Insurance Information

Who is responsible for this account? _____

Relationship to patient (self, spouse, etc.)_____

Insurance Co. _____

Group # _____

Subscriber's name _____

Birthdate _____ _____

Is the patient covered by additional insurance? ____ Yes ____ No

Relationship to patient _____

Insurance Co. _____

Group # _____

Accident Information

Is condition due to an accident? Yes ____ No ____ Date _____

Type of accident: Auto _____ Work _____ Other _____

If Work Comp: Claim # _____ Date of accident:_____

Ins. Co. Name: _____

Adjuster: _____ Phone: _____

If Auto: Has fault been established? Yours _____ Other _____
If accident is your fault, please fill out Your Auto Insurance Section; if not, please fill out At Fault Driver's Insurance Section.

Your Auto Insurance Company: _____

Adjuster: _____ Phone _____

Claim # _____

At Fault Driver's Insurance Co.:_____

Adjuster: _____ Phone _____

Policy holder: _____ Claim # _____

If you have an attorney, may we contact him/her regarding your care and payment?_____ Name, number:_____