WellnessPointe
Family Health Starts Here
Longview Wellness Center, Inc.

Registration Form

Patient Information

Date of Birth:_____

Name: _____ **Soc. Sec. #:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **County:** _____

Email Address: _____

Home/Mobile Phone: _____**Secondary Phone:** _____

Demographic Information

Sex: ◯ Male ◯ Female **Primary Language:** _____

Race: Please Check One

◯ White/Caucasian ◯ Black/African American ◯ American Indian/Alaskan Native
◯ Asian ◯ Native Hawaiian ◯ Pacific Islander
◯ More than one Race ◯ Other

Ethnicity: Please Check One

◯ Hispanic ◯ Non-Hispanic

Referral Source: Please Check one

◯ Patient of Wellness Pointe ◯ GSMC ER ◯ GSMC L&D ◯ Outside Physician/Clinic
◯ Longview Regional ER ◯ Longview Regional L&D ◯ ETMC Gilmer
◯ WP Employee ◯ WP Social Services ◯ Health Fair ◯ WIC Kilgore
◯ WIC Longview ◯ Community Organization ◯ Online ◯ TV/Radio
◯ Billboard/Print Ad

Other: _____

Insurance Information

Insurance Carrier/Name: _____

Insured ID/Policy Number: _____**Group Number:** _____

Insurance Phone Number: _____ **Insured Date of Birth**:_____

Insured Name: _____ **Insured SSN:** _____

*A Copy of Insurance Card will need to be on file each year.

If the patient is a child:

Guarantor's Name: _____ **Guarantor's date of birth:** _____

Is Guarantor a Patient here? ◯Yes ◯No

Guarantor's Phone: _____

Additional Information

Number in Household (how many live in YOUR household)*: _____

Monthly Income of YOUR household*: _____

Emergency Contact: _____

Phone Number: _____ **Relationship:** _____

Preferred Pharmacy: _____ **Pharmacy Location**: _____

Marital Status: Please Check One

◯Single ◯Married ◯Separated ◯Divorced ◯Widowed ◯Other

Are you a Veteran: ◯yes ◯no

Assignment and Release

Assignment of Benefits: I authorize payment of medical benefits to the named provider for professional services rendered.

Signed: _____

Release of Information: I authorized the release of any medical information necessary to process this claim.

Signed: _____ **Date:** _____