

The Center for Health and Restoration, Inc.

**Patient Demographics:**

Last Name:  First Name:  MI:   
DOB:  Gender:  SSN:   
Marital Status:  Employ. Status  Prof. Title:   
Addr Line 1:  Addr Line 2:   
City:  State:  Zip:   
Home Phone:  Work Phone:  Work Ext:   
Cell Phone:  Fax:  Email:

**Employment Information:**

Employ. Name  Employ. Phone   
Addr Line 1:  Addr Line 2:   
Employer City:  State:  Zip:

**Emergency Contact:**

Contact Name:  Relationship to Patient:   
Addr Line 1:  Addr Line 2:   
City:  State:  Zip:   
Home Phone:  Cell Phone:

**Primary Insurance:**

Insurance Co. Name:   
**Primary Insured:** Last Name:  First Name:  MI:   
DOB:  SSN of Primary   
Patient Relationship To Primary Insured:   
Subscriber ID:  Group No:  Plan Name:

**Secondary Insurance:**

Insurance Co. Name:   
**Secondary Insured:** Last Name:  First Name:  MI:   
DOB:  SSN of Secondary   
Patient Relationship To Secondary Insured:   
Subscriber ID:  Group No:  Plan Name:

**Guarantor Information:** (if different from primary insured or patient)

**Guarantor:** Last Name:  First Name:  MI: