DelVal Integrative Health Partners, LLC
Rebecca Nice, DO
205 Telford Pike
Telford, PA 18969
Phone 215.383.1305
Fax 215.383.1306

PATIENT INFORMATION

(Please Print) (Circle one)
Name_____D.O.B._____Sex M F Age_____

Address_____ SS#_____

(Circle one)
City_____State____Zip_____ Marital Status S M W D

Home Phone_(____)_____Cell Phone_(____)_____

Employer_____ Work Phone_(____)_____

Spouse's Name_____ D.O.B_____

Spouse's Employer_____

Emergency Contact_____Phone _(____)_____

**(Name of Individual Doctor
NOT Group Name)****
***Referring Doctor_____ Pharmacy_____Phone (___)_____**

INSURANCE INFORMATION

(Please present insurance cards to receptionist) ID Checked_____

Primary Ins._____Address_____

ID#_____Group#_____Subscribers Name_____

Subscribers Relationship to Patient_____ Subscribers D.O.B._____

Secondary Ins._____ Address_____

ID#_____Group#_____Subscribers Name_____

Subscribers Relationship to Patient_____Subscribers D.O.B._____

Is patient a student?____ Full time_____Part time_____

Patient Race__ American Indian__ Asian__ African American
(Circle One) __Caucasian__Other

Ethnicity__Non Hispanic Language__English__Spanish__Other
__ Hispanic

WORKMANS COMPENSATION OR AUTO ACCIDENT
(If patient's condition is work related or auto accident, please fill in the following information)

Claim number for filing claim_____

Insurance Company _____

Insurance Address_____

Workplace Name (if W.Comp)_____

Work Address_____

Date of injury/accident_____
_____

ASSIGNMENT of BENEFITS/AUTHORIZATION to RELEASE INFORMATION

I request that payment of authorized Medicare benefits and/or private insurance benefits be made on my behalf to DelVal Integrative Health Partners, LLC, Rebecca Nice, DO, for any service furnished me by physicians. This also applies to all Medigap and other secondary insurance. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or private insurance companies any information needed to determine these benefits or the benefits payable for related services.

Authorized Signature_____Date_____

Parent/Guardian_____Date_____

OFFICE POLICIES
I understand that patient co-pays are due at time of visit. An additional $10 service fee will be billed if co-pay is not paid at time of visit.

Authorized Signature_____Date_____

Office Use Only-Photo ID and Insurance card copied_____Office Staff Initial_____