Watershed Wellness, LLC.

Patient Information – Financial Information

DOB ____/____/____ Age: ______

Name: ____

Social Security # ______-____-________

Address: ____

City: ____________________________ State: __________ Zip: __________________

Best phone number to reach you: ______-______-________

Alternate phone number: ______-______-________

Emergency Contact Person: ___________________________ Ph: ____________________

Patient's Email Address:____

Would you like to receive our quarterly electronic newsletter supplying you with seasonal health and wellness information, recipes, acupressure and self care?

Yes No

Insurance Company: ____

ID# _________________________________ Group # _____________________________

Insurance Company Phone Number: ______-______-________