

Mountain State Wellness, PLLC

“Our Vision is Lifetime Family Wellness”

Please complete the following information:

Member Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Business phone: _____

E-mail address: _____

Social Security Number: _____ Birth date: _____

Occupation: _____ Employer: _____

Spouse: _____ Employer: _____

Children: _____

Parents (If member is a child): _____

Family Doctor: _____ Phone: _____

In case of emergency contact: _____

Phone: _____

(Please circle)

Is your PRIMARY or SECONDARY Insurance P.E.I.A? **Yes** **No**

Are you a Medicare recipient? **Yes** **No**

Are you a Medicaid recipient? **Yes** **No**

Whom may we thank for referring you to our office? _____

What are your expectations from receiving spinal care? _____

Signature