Transform Within Wellness Center, LLC
700 Commerce Drive, Suite 295
Woodbury, MN 55125
(651) 442-8214

CLIENT ACCOUNT INFORMATION

Date: _____ Therapist: _____

Patient Information:

Patient Name (Print): _____ Date of Birth: _____
Last Name First Name Initial
Age: _____ Gender of Legal Record: Male_____ Female____ Married___ Single ___ Divorced____ Partner___

Street Address: _____
City State Zip
Cell Phone: _____ Home phone:_____ Work Phone: _____

Is it ok to leave a message? And if so, which number do you prefer I call? _____
Email address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship:_____ Emergency Phone Number:_____

Please complete the following with Primary Health Insurance Information:
Name of Insurance Company_____ Phone # Insurance _____

Name of Policy Holder _____

Address Of Policy Holder_____

City_____ State_____ Zip_____

Relationship to Policy Holder_____ Date of Birth of Policy Holder: _____

Policy #_____ Group Number_____

Please complete the following with Secondary Health Insurance Information:
Name of Insurance Company_____ Phone # Insurance _____

Name of Policy Holder _____

Address Of Policy Holder_____

City_____ State_____ Zip_____

Relationship to Policy Holder_____ Date of Birth of Policy Holder: _____

Policy #_____ Group Number_____

Responsibly Party: ***Where should the patient's portion of the bill be sent, if not to the patient? This person will be contacted if clients has an outstanding balance and client is not responding to company's attempts to contact client. Giving the information and the signing of the Consent Form gives Transform Within Wellness Center, LLC the right to contact this person without further releases of information.***

Name: _____ Relationship: _____ Phone: _____

Address: _____