

IDA KARLIN HEALING CENTER
319 5TH STREET SW, PUYALLUP, WA 98371
PHONE: 253.848.0351

GENERAL INFORMATION

FATHER'S NAME _____ DOB ____ / ____ / ____

MOTHER'S NAME _____ DOB ____ / ____ / ____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

GUARANTOR'S SSN: _____ - _____ - _____

SPOUSE'S SSN: _____ - _____ - _____

HOME PHONE NUMBER _____

GUARANTOR OF INSURANCE

EMPLOYER _____

BUSINESS PHONE NUMBER _____

PRIMARY INSURANCE _____

SUBSCRIBER # _____ GROUP # _____

ADDRESS _____

SECONDARY INSURANCE _____

SUBSCRIBER # _____ GROUP # _____

ADDRESS _____

RELATIVE OR FRIEND TO BE CALLED IN CASE OF EMERGENCY

PHONE# _____

PATIENT NAMES AND BIRTHDATES

1. _____ DOB ____ / ____ / ____

2. _____ DOB ____ / ____ / ____

3. _____ DOB ____ / ____ / ____

4. _____ DOB ____ / ____ / ____

I hereby authorize treatment and the doctor to release necessary information to my insurance company. I authorize direct payment of medical payments to Dr. Peñalver.

SIGNATURE _____ DATE ____ / ____ / ____