Prana Health
Ad Vitam - For Life

Patient Introduction Date _____

Name_____ _____ _____
First Middle (Optional) Last

Birth Date _____ Sex _____

Home Phone _____ Cell Phone _____

Home Address_____

City_____ State_____ Zip_____

Business Name/Phone _____

Do you wish to receive email notification?
( ) Yes: email address _____@_____._____
( ) No

Health Insurance Information

Primary Insurance Company Name_____

Group _____ ID#_____

Company Address_____

Secondary Insurance Company Name_____

Group _____ ID#_____

Company Address_____

In case of an emergency please notify_____

Phone_____ Relationship_____

PHARMACY INFORMATION

Pharmacy Name: _____

Address: Street_____ Phone_____
City_____ Fax_____
State: ☐NC ☐Other_____ZIP: _____

Assignment of benefits: I hereby authorize the payment to be made directly to NIDRA LLC of benefits due for my services. I understand I am finically responsible for charges not covered by this authorization.

Date_____ Sign_____

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