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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