Patient Forms

Top Wellness Center
725 River Rd #117,
Edgewater, NJ 07020

Basic Information

Full Name ______________________________
First | Middle | Last | Suffix

Sex ◯ Male ◯ Female ◯ Unknown

Date of Birth ____ / ____ / ____

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number ______________________

Email ______________________

Social Security Number ______________________

Address Line 1 ______________________

Address Line 2 ______________________

City ______________________

State __________ **Zip** __________

Marital Status ______________________

Maiden Last ______________________

Driver's License State ______________________

Driver's License # ______________________

Demographics

Sexual Orientation ______________________

Gender Identity ______________________

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify

Ethnicity ______________________

Race ______________________

Language ______________________

Emergency Contact

Relationship to Contact ______________________

Full Name ______________________________
First | Middle | Last

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number ______________________

Email ______________________

Address Line 1 ______________________

Address Line 2 ______________________

City ______________________

State __________ **Zip** __________

Financial Information

Responsible Party

Who will be financially responsible for you? ○ Myself ○ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact ______________________

Full Name ______________________
First Middle Last

Primary Phone ○ **Home** ○ **Mobile** ○ **Work** **Phone Number** ______________________

Method of Payment

What will be your method of payment? ○ Insurance ○ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company ______________________ **Policy Number** ______________________

Insurance Plan ______________________ **Insurance Phone Number** ______________________

Group Number ______________________

Insurance Company Address ______________________ **Address Line 2** ______________________

City ______________________ **State** __________ **Zip** __________

Relationship to Primary Policy Holder ______________________

If you are not the primary policy holder, please fill out the following:

Full Name ______________________
First Middle Last

Sex ○ Male ○ Female ○ Unknown **Date of Birth** ______ / ______ / ______

Policy ID Number ______________________ **Social Security Number** ______________________

Policy Holder Address ______________________ **Address Line 2** ______________________

City ______________________ **State** __________ **Zip** __________

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company ______ **Policy Number** ______

Insurance Plan ______ **Insurance Phone Number** ______

Group Number ______

Insurance Company Address ______ **Address Line 2** ______

City ______ **State** ______ **Zip** ______

Relationship to Secondary Policy Holder ______

If you are not the secondary policy holder, please fill out the following:

Full Name ______
First Middle Last

Sex ○ Male ○ Female ○ Unknown **Date of Birth** ___ / ___ / ___

Insurance ID Number ______ **Social Security Number** ______

Policy Holder Address ______ **Address Line 2** ______

City ______ **State** ______ **Zip** ______

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us? ______