WHOLE FOODS MARKET®
MEDICAL WELLNESS
CENTER

PATIENT REGISTRATION FORM

Personal Information

First Name _____Last Name_____ Preferred Name_____

Date of Birth _____ Age _____ Sex: ☐ Male ☐ Female Ethnicity _____

Marital Status: ☐ Single ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Preferred Language _____ Email _____

Home Phone _____Cell Phone _____

Home Address: Street_____

Unit/Suite _____City _____ State_____ Zip_____

Occupation_____ (If with Whole Foods Market, store location :_____)

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Retired

Emergency Contact

First Name _____ Last Name _____

Phone _____ Relationship _____

Patients Who Are Minors

Individual(s) (Other than Primary Guardian) Authorized to Receive Health Information:

Name:_____ Relationship:_____

Preferred Pharmacy: (*Please choose a pharmacy to have on file*)

Name:_____ Address:_____ Phone:_____

I consent to be notified via mail, email, text messaging, and/or telephone by The Whole Foods Market Medical and Wellness Center practice of information available regarding care, test results, appointments, and other pertinent information.

Patient Signature_____ **Date**_____

Parent or Guardian (*if patient is a minor*)_____ **Date**_____

WHOLE FOODS MARKET®
MEDICAL + WELLNESS
CENTER

Financial Information

First Name _____ Middle Name _____

Last Name _____ SSN _____

Primary Insurance

First Name of Insurance Holder _____ Middle Name _____

Last Name _____ SSN _____

Address of Primary Holder: Street_____ Unit/Suite _____

City _____ State____ Zip_____ Phone number:_____

Date of Birth _____ Relationship to Patient _____

Insurance Company Name _____

Insurance ID # _____ Group Number _____

Secondary Insurance

First Name of Insurance Holder _____ Middle Name _____

Last Name_____ SSN _____

Date of Birth _____ (mm/dd/yy) Relationship to Patient _____

Insurance Company Name _____

Insurance ID # _____ Group Number _____

PATIENTS **MUST** FILL OUT PATIENT INFORMATION FORMS **PRIOR** TO SEEING THE DOCTOR
WE WILL ASK TO SEE YOUR INSURANCE CARD ON YOUR FIRST VISIT AND WILL SCAN YOUR CARD INTO OUR SYSTEM AS NEEDED TO KEEP OUR INFORMATION CURRENT. WE MAY ASK FOR THIS INFORMATION ON A REGULAR BASIS IN ORDER TO ENSURE THAT NO CHANGE IN BENEFITS OR CARRIER HAS OCCURRED. PLEASE NOTIFY US IF YOUR INSURANCE CARRIER OR POLICY HAS CHANGED.