PHOENIX ONE HEALTH SOLUTIONS

PATIENT INFORMATION SHEET			
First Name:	(MI)		Last Name:
DOB:	Sex: Male / Female	Marital Status: Single - Married - Widowed - Divorced	
Height:	Body Weight:		
Address:			
Phone Number:	Email:		
Social Security Number:		Emergency Contact:	
		Contact Phone Number:	
		Relationship to Patient:	

Insurance Information		
Insurance Company:		Phone Number:
Insurance Identification Number:		Groupe Number:
Insured's Name:		Relationship to Patient: SELF / SPOUSE / DEPENDENT
Insured's Employer:		Work Number:
Insured's Social Security Number:	DOB:	Sex: Male / Female

Secondary Insurance Information		
Insurance Company:		Phone Number:
Insurance Identification Number:		Groupe Number:
Insured's Name:		Relationship to Patient: SELF / SPOUSE / DEPENDENT
Insured's Employer:		Work Number:
Insured's Social Security Number:	DOB:	Sex: Male / Female

I hereby assign, transfer, and set over to NextGen RPM, the ability to send claims to my insurance company for services rendered during the time of my monthly monitoring and treatments. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature: _____ Date: _____

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Health History Questionnaire	
Date:	Referring Physician:
Name:	Family Doctor:
DOB:	Specialist Doctor:

BodyComp-Plus Biometric Testing Items *Check below if you own these items:*	
	- Blood Pressure Monitor - Glucometer (Blood Sugar) - Body Composition Scale / Skulpt Body Composition Scanner - Pulse Oximeter (Oxygen) - Measurements Tape (Body Circumstances)

Current Medication (Please list all meds including vitamins and OTC meds)		
Medication	Why Prescribed	Doesage

Medical History (Please list all medical conditions)

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