Curative Care Center
Health Care Clinic

CLIENT INFORMATION & ENROLLMENT FORM

DATE:_____/_____/_____

CLIENT INFORMATION *(please print)*

LAST NAME: **FIRST NAME:** **MI:**

DATE OF BIRTH: **SSN:** - -

STREET ADDRESS: **APT:**

CITY: **STATE:** **ZIP:**

HOME PHONE: **MOBILE:** **OTHER:**

GENDER: **PREFERRED LANGUAGE:**

CLIENT MEDICAL & PROVIDER INFORMATION *(please print)*

Allergies:

Current Medications:

Primary Medical Provider:

Primary Insurance Information (if applicable):

Insurance ID : **Group #**

Secondary Insurance Information (if applicable):

Insurance ID : **Group #**

HOW DID YOU HEAR ABOUT US? *(please circle all that apply)*

Facebook Google Social Media Flyer Family/Friends Event Outdoor Sign

Website Mailout Word of Mouth Doctor's Office: _____ Other: _____

CLIENT SIGNATURE:_____ TODAY'S DATE: _____/_____/_____

WITNESS SIGNATURE:_____ TODAY'S DATE: _____/_____/_____