

## Calm Spirit Wellness Clinic – Personal Information

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone Number \_\_\_\_\_

Cell Phone # \_\_\_\_\_

Email address \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone Number \_\_\_\_\_

Insurance Company \_\_\_\_\_ phone # \_\_\_\_\_

Primary Card Holders DOB \_\_\_\_\_

Insurance membership # \_\_\_\_\_