



## Patient Information

Last name		First name		MI
Date of Birth		Social Security Number		
Address				
City			State	Zip Code
Home Phone (    )			Work Phone (    )	
Occupation	Employer			
Employer Address				
Marital Status		Spouse/Partner		
Emergency Contact (outside of home) Name		Emergency Contact Phone number		
Insurance Name and Address				
Insured Member's Name			Policy Number	
Who referred you to Dr. Stanger?				

I AUTHORIZE ANN STANGER MD AND THE INNOVATIVE HEALTH CLINIC TO BILL THE ABOVE INSURANCE COMPANY AND RELEASE ANY PERTINENT MEDICAL INFORMATION TO THE INSURANCE COMPANY TO RECEIVE PAYMENT.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**SPECIALIZING IN LONGEVITY MEDICINE AND NATURAL HORMONE THERAPY**