

Arraya Acupuncture and Wellness
Patient Billing Information

Patient's Information:

Last _____ First _____ MI _____
Street _____ City _____ State _____ Zip _____
Tel (H) _____ Tel (C) _____ Tel (W) _____
DOB ____/____/_____ Marital Status (circle one): S M D Other
Employed? Y / N Employer _____
FT / PT Student? Y / N

Insured's Information:

Insurance Plan / Program _____
Group ID Number _____ Policy Number _____
Employer _____ DOB ____/____/_____
Last _____ First _____ MI _____
Relation to Patient _____ Phone _____ Sex: M / F Other
Street _____ City _____ State _____ Zip _____
(If different than above)

Is There Another Insurance Plan? Y / N

Insurance Plan / Program _____
Group ID Number _____ Policy Number _____

OFFICE USE ONLY **

Diagnosis Code(s):