

**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):