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## ACCOUNT INFORMATION--APPLE HEALTH & MEDICARE

**Client's Name:** _____
Last First Middle Initial

**Address:** _____
Street City State Zip Code

**Client's DOB:** ____/____/____ **Sex (circle): Male Female Other Prefer not to say**

**Phone: Home: (____) _____ Cell: (____) _____ Work: (____) _____**

**E-mail:** _____

**Mother/Father/Other _____ Name: _____**

**Phone:Home: (____) _____ Cell :(____) _____ Work: (____)_____**

**Mother/Father/Other _____ Name: _____**

**Phone: Home: (____) _____ Cell:(____)_____ Work: (____)_____**

**Payment Source: (check all that apply)**
**____ Insurance ____ DDD _____ Private Pay (Cash/Check) ____Other_____**

### Primary Insurance Information

**Primary Cardholder/Subscriber Information:**

**Name: _____ DOB: ____/____/____**

**Provider One Number_____**

**Insurance Carrier: Molina CHPW UHC Community Plan**

**Wellpoint (Amerigroup) Coordinated Care Medicare**

**ID Number_____**