Naturopathic
Health Center, LLC

PATIENT INFORMATION

Last Name____

First Name_______________________ Middle _________

Birthdate ________________ Age______ Gender ☐ M ☐ F

Street Address____________________________________

City__________________ State______ Zip_____________

Email____

Social Security # _________________________________

Employer____

Occupation_______________________________________

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated

Spouse/Partner's Name_____________________________

Whom can we thank for referring you?

____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Insurance Company _________________________________

Plan Name ____

ID # ____

Group # ____

Primary Physician___________________________________

Does your visit require a referral? ☐ Yes ☐ No ☐ Unsure

Is the patient the primary subscriber? ☐ Yes ☐ No

If no, please complete subscriber information below:

Name ____

Birthdate ________________ SS# ____________________

Relationship to patient _______________________________

PATIENT PHONE NUMBERS

Home (___________) _______________________________

Work (___________) _______________________________

Cell (___________) _______________________________

Best time and place to reach you ____________________

Is it OK to leave a message? ☐ Yes ☐ No

EMERGENCY CONTACT

Name ____

Relationship ______________________________________

Home (_________)__________________________________

Work (_________) _________________________________

Cell (__________) _________________________________

I authorize Naturopathic Health Center, LLC to disclose necessary health care information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I request that payment of authorized benefits be made on my behalf to Naturopathic Health Center, LLC for any services furnished me by Naturopathic Health Center, LLC. I understand and agree that regardless of my insurance status I am responsible for the balance on this account for any services, medications, or laboratory work.

____ ____________________

Signature of patient, parent, guardian, or representative Date