

**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