



Patient Information Form

Personal Information

Name: _____ / _____ / _____
(Last) (First) (Sex) (Date of birth)

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Cell phone: (____) _____ Work: (____) _____

Email address that you would like to be contacted at:

Cell phone carrier _____

Contact preference circle one: PHONE CELL EMAIL

How did you hear of Nature's Helper Medical Clinic?

Website: _____ Natural Health Magazine: _____ Insurance Company: _____ HealthPros.com: _____

Other: _____ Who referred you? _____

Additional Information

Today's date: ____ / ____ / ____ If patient is a minor: parent/ guardian name: _____

Employer: _____ Occupation: _____

Work address: _____ City: _____ State: _____ Zip: _____

MD physician: _____ City: _____ Phone: (____) _____

Marital status (circle): Single Married Separated Divorced With Partner Widow(er)

Whom may we contact in case of an emergency: _____ Relationship: _____

Emergency contact phone #: (____) _____

Insurance Information

Insurance Company: _____ Co-Pay: _____ ID #: _____

Primary Insured's Name: _____ Relationship to Patient: _____

Address of Insured (If different from above):

Phone: (____) _____ Date of Birth: ____ / ____ / ____ Gender: _____

Employer (If different from above) _____

Signatures

Patient's Signature Parent or Guardian's Signature _____ / _____
Date