Patient Information Form

Personal Information

Name:____ ______ ______ ____/____/____
(Last) *(First)* *(Sex)* *(Date of birth)*
Address: ________________________________ City: ___________ State: ____ Zip: ______

Phone: (______)__________ Cell phone: (______)__________Work: (______)______________
Age:________
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:______HealthProfs.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

Please be advised that e-mailed receipts may contain Protected Information and e-mail communication is not encrypted. By consenting you are acknowledging these confidentiality and security limitations.