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:_____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