

NOR CAL Natural Medicine
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How did you hear of us?

Yellow Pages: ___ Radio/TV: ___ Sign: ___ Internet: ___ Family/Friend: ___ Name: _____

Were you referred by another Health Care Provider? ___ Yes ___ No

If "Yes", please provide referring Physicians name, address, and phone number: _____

Patient Demographics

Name: _____ Sex: _____ Date of Birth: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Additional Patient Information

Today's Date: _____ Primary Care Physician: _____

Employer: _____ Occupation: _____

Work Address: _____ City: _____ St: _____ Zip: _____

Name of nearest relative not living with you: _____ Relation: _____ Phone: _____

Material Status (circle): Single Married Separated Divorced With Partner Widow(er)

Name of Spouse/Significant Other: _____ S.S.#: _____

Whom may we contact in an emergency: _____ Relation: _____

Emergency Contact #: (____) _____

Insurance Information (Please provide card for Coping)

Insurance Company: _____ Phone: _____

Name of Insured: _____ Relationship to Insured: _____

S.S.#: ____ / ____ / ____ Policy #: _____ Group#: _____

Insurance Information

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Furthermore, in the event that payment is not made on this account and it is place with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to the maximum of 50% of our outstanding balance at the time the account is placed with the agency. Should legal action also be necessary to collect the account, I/we agree to pay attorney's fees and court costs incurred for the collection. Releases may be requested prior to specific procedures being performed (i.e., minor surgery, etc.)

Clinic Policy requires full payment at the time of services

Patient's Signature _____ **Date** _____