Today's date: **PLEASE COMPLETE AND SIGN** New Patient ☐ Updated info: ☐

ACCOUNT# PATIENT INFORMATION FCOF RCOF

Last name: First name: Middle Initial: Marital status: Single ☐ Mar ☐ Partner ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? Social Security no.: Birth date: Age: Sex: ☐ M ☐ F

Street address (Mailing address for statements) City: State: Zip:

Email address: Evening phone no: ( )

Prefer to receive messages or coupons: Day# ☐ Evening# ☐ Email ☐ None ☐

Employer Daytime phone no.: ( )

Chose clinic because/referred to clinic by: ☐ Location ☐ Family ☐ Friend ☐ Insurance plan ☐ Physician ☐ Seminar or event ☐ Dex Yellow Pages ☐ Verizon Superpages ☐ Redirect guide ☐ Other

NAME OF PERSON WHO REFERRED YOU (if applicable):

We may require a credit card on file to receive discounted rates. Please include:

Credit card type: *Credit card number:* *Expiration:*

3-digit verification code:

PRIVATE HEALTH INSURANCE INFORMATION

(**Please give your insurance card to the receptionist**.)

Name of primary insurance: Address: City: State: ZIP Code:

Name of secondary insurance:

Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-pay/insurance:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IF YOU HAVE A SECONDARY INSURANCE YOU WOULD LIKE US TO BILL PLEASE NOTIFY THE RECEPTIONIST.

MOTOR VEHICLE ACCIDENT OR WORKER'S COMPENSATION INSURANCE INFORMATION

☐ Work comp ☐ MVA (Please give your insurance card to the receptionist.)

Name of insurance plan: Address: City: State: ZIP Code:

Claim representative's name: Phone no.: ( ) Attorney's name: Phone no.: ( )

Date of injury: Claim number: Injured body part:

Employer at time of injury name:

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Phone no.: ( )

SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance per the credit policies of the All Naturopathic Clinic. I also authorize the All Naturopathic Clinic or insurance company to release any information required to process my claims.

Patient or Guardian signature: Date:

Prescriptions currently taking dosage:	Supplements currently taking dosage:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.

Personal Habits:

Please circle any of the following substances that you use regularly: Tobacco Coffee/black tea/cola Alcohol Recreational drugs

Average Daily Diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you exercise regularly □ Yes □ No

If yes, what type? _____

How long? _____ How often? _____

Any known allergies? Food: _____ Inhalants: _____ Drugs:_____

Past History:

Personal and Family History: Please check the "yes" box next to each condition that applies to you or a family member. Note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "Relationship" column.

	Yes	Relationship	Dates Resolved Past(P)Current (C)		Yes	Relationship	Dates Resolved Past(P)Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Auto Immune Disease			
Epilepsy				Thyroid Disorder			
Other							

Are you currently under the care of a medical professional? Yes No
If yes, please list the name of the facility and physician:
_____

Hospitalizations:
_____
_____

Serious illness and injuries:
_____
_____
_____

Date of last physical/annual exam_____ Date of last blood test _____

What are your most important health concerns?

1. _____
2. _____
3. _____
4. _____
5. _____

Review of Systems:
Please list any symptoms you are currently experiencing in the following areas
Severity of current complaint(s) (0-best, 10-worst):

	Symptoms	Severity		Symptoms	Severity
Head:			Blood/Peripheral Vascular:		
Ears:			Gastrointestinal:		
Eyes:			Genito-Urinary:		
Nose:			Endocrine:		
Throat:			Neurological:		
Respiratory:			Musculo-Skeletal		
Mood/Psych:			Skin:		
Cardiovascular:			Other:		

Last menstrual period (♀): _____