Whole Health Concord

Naturopathic Medical Center
Dr. Laura Riley

Confidential Patient Information

Today's Date: ____________

Name:______________________ ____ _____ _____
(Last) (First) (Sex) (Date of birth) (S.S. #)

Perm. Address: ____________________ City: __________ State: ____ Zip: ________

Phone Perm: ____________ Cell Phone: ____________ Phone Work: ____________

Driver's License #: ______________ State: ______ Email Address: ______________

How did you hear of us?

Yellow Pages: ☐ Newspaper: ☐ Radio/TV: ☐ Internet: ☐ Sign: ☐

Were you referred by another physician: Yes ☐ No ☐

Referring Physician's Name: ______________________ Phone: ______________

Address, City, State, Zip: ____

Who is your current Physician: ______________________ Phone: ______________

Employer: __________________ Occupation:____________ Phone: __________

Perm. Address: ____________________ City: __________ State: ____ Zip: ________

Nearest relative not living with you: ______________Relation: ________ Phone:__________

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ With Partner ☐ Widow(er) ☐

Name of Spouse (or parent for minor child): ______________ S.S. #: _____

Emergency Contact: ____________ Relationship to you: ________ Phone: __________

Insurance Company: ______________________________ Phone: ______________

Name of Insured: ______________________ Relationship to the Insured: ____________

S.S. #: _____ Policy #: __________________ Group #: ______________

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.

Clinic Policy requires payment at time of services.

______________________ ______________________ __________

Patient's Signature **Parent or Guardian's Signature** **Date**

______________________ ______________________

Please Print Name **Please Print Name**