Today's date:

PLEASE COMPLETE AND SIGN

PATIENT INFORMATION

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? Birth date: Age: Sex: ☐ M ☐ F

Mailing address City: State: Zip:

Email address: Evening phone no:

Prefer to receive messages: Day# ☐ Evening# ☐ Email ☐ None ☐ ( )

Chose clinic because/referred to clinic by: ☐ Location ☐ Family ☐ Friend ☐ Insurance plan ☐ Physician

NAME OF PERSON WHO REFERRED YOU (if applicable):

PRIVATE HEALTH INSURANCE INFORMATION

(If you are using Insurance, fill out this box and give your insurance card to the receptionist.)

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

Subscriber's name:

Birth date: Group no.: Policy/ID no.:

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 Nature Cures Clinic. I also authorize Nature Cures Clinic or insurance company to release any information required to process my claims.

Patient or Guardian signature: Date: