LAKE NATURAL MEDICINE

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Confidential Patient Information

Today's Date: _____

First Name _____ **Last Name** _____ **Middle Initial** ____

DOB: ____/____/_____ Age: _____ Gender: (M) ___ (F) ___ Height: _____ Weight: _____

Preferred nickname (if any) _____
Responsible Party (if patient is a minor) _____
Street Address _____
City, State, Zip _____
Phone # (hm) _____ (cell) _____ (wk) _____
Phone # preferred for appointment reminder calls (check one) ___ (hm) ___ (cell)
Email: _____

Emergency Contact (name & relationship) _____ Phone # _____
Person(s) whom you authorize to speak to our clinic about your medical condition / appointments:
(names, relationship) _____

Social History:
Occupation/Employer _____ Type of work _____
Hobbies _____
Marital Status: S___ M___ W___ Partner ___
Name of Spouse/Partner _____ # Children _____
How did you hear about our clinic? _____

Insurance Information (if paying by insurance):
Company _____
ID # _____ Group# _____
Insured's Name _____ Relationship to Insured _____

Guarantor's Information (if other than Self):
Address _____
_____
Phone #_____
Insured's DOB _____ Gender ___ (M) ___ (F)

Signature on file: I authorize this office to bill my insurance company for services and to communicate with them and share PHI (protected health information) as needed to facilitate payment.

_____ **Patient (or Guardian) Signature**