SALISH ISLAND NATUROPATHIC, L.L.C.

PATIENT REGISTRATION

First Name: M.I. Last Name:

Street Address:

City: State: Zip:

Email: D.O.B:

Employer: Mobile Phone #: MSG Okay: ( ) YES ( ) NO

Gender Identity: Home Phone #: MSG Okay: ( ) YES ( ) NO

Preferred Pronoun: Work Phone #: MSG Okay: ( ) YES ( ) NO

Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Dependent ( )Partnered ( )Other

Responsible Party: Phone:

Address: City, ST, ZIP:

Emergency Contact: Phone:

Referred By:

Preferred Pharmacy:

Blood Type:

Diet Diary: Usual Breakfast:

Freq. Lunch:

Frequent Dinner:

Favorite Snacks:

Supplements:

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature: **Date:**