Patient Information Form | Specialty Natural Medicine Inc PC

Last Name:_____ First Name:_____ Middle Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Other:_____

May we leave confidential voice-mail messages for you at any of the above numbers? Home:☐ Work:☐ Cell: ☐ Other: ☐

Primary Email:_____ Secondary Email:_____

Date of Birth:_____ Age:_____ Gender:_____ SS#:_____ ☐ **check here to receive email updates**

Insurance Company(s):_____ - ***Please provide us with your insurance card(s)**

Relationship to Primary: self:☐ spouse:☐ child:☐ parent:☐ **and your drivers license to photocopy**

Primary on insurance if not self:_____ **Primary's birth date:**_____ **Primary's gender:**_____

Employer/School (of primary or self if you are primary):_____ **Primary's SSN:**_____

Mother's name (minors):_____ Father's name (minors):_____

Emergency contact name:_____ Relationship to emergency contact:_____Emergency contact phone:_____

Marital Status: Single:☐ Married:☐ Divorced:☐ Separated:☐ Widowed:☐ Domestic Partner:☐

How did you hear about us?

Personal Referral _____ Are they a patient here? Yes: ☐ No: ☐

☐ Website (which one) _____ ☐Workshop/Lecture _____

☐ Insurance Co (which one) _____ ☐Yellow Pages ☐Other:_____

Guardian Information/Primary on Insurance policy

This section must be completed if someone other than the patient is financially responsible for the patient's account

Last Name:_____ First Name:_____ Middle Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Email:_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above named patient and that I am subject to all financial terms listed below.

X _____ _____

Guardian's Signature and Relationship to Patient **Date**

Terms of Admission

Financial Terms: Payment is due at the time of services. Please refer to your financial agreement

Privacy Terms:

These records will not be disclosed to others unless you direct us to do so or applicable laws/ insurance authorize, request or compel us to do so. The doctor requests your consent in professional confidence to consult your case with your other health care professionals if she determines that this will benefit the coordination of your care.

X _____ X _____

Patient's Signature **Date** **Guardian/Representative's Signature** **Date**

Specialty Natural Medicine Inc PC
Dr. Kathleen Janel Dr Maegan Knutson
Dr. Christine Beasley

8423 Mukilteo Speedway, Ste 101
Mukilteo, Washington
98275

(425)423-0878
fax: (425)669-9538