

Naturopathic Muscle and Joint Clinic

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Confidential Patient Information

Please fill in all portions of this form. If you need help, please ask.

Patient Information

First Name _____ Last Name _____ Middle Initial _____

Address _____

Apt/Suite _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Number _____ Work Extension _____

Cell Number _____

Date of Birth _____ M/F _____

Email _____

Complete privacy is adhered to. Your email will not be sold or shared with anyone without prior written agreement. This is for possible email-health newsletters and/or possible future correspondence.

Emergency Contact

Whom may we contact in case of emergency? _____ Contact Phone: _____

Contact Cell Phone: _____ relationship to patient (optional) _____

Employment and Insurance Information

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICE

Employer _____ Title _____

Employer Phone _____

Address _____ Suite _____ City _____ State _____ Zip _____

Insurance Provider _____ Subscriber ID _____ Group No _____

Plan Name _____

Subscriber's SSN# _____ (Important: WE NEED THIS to bill your insurance and will be kept under strict HIPA Guidelines.)

Referred By

Whom may we thank for referring us? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I hereby authorize the undersigned physician the right 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 charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance

Patient's Signature

Parent or Guardian Signature

Date