ROOTS FOR HEALTH
NATUROPATHIC MEDICINE

Patient Registration Form

First Name: ______ Middle: ______ Last: ______

Street Address: ______ Email: ______

City: ______ State: ______ ZIP: ______

SSN: ______ Gender: ☐ M ☐ F ☐ Other Home Ph: ( )

Date of Birth: / / Age: ______ Alt. Ph: ( )

Employment Status: ☐ Employed ☐ F/T Student ☐ P/T Student ☐ Retired ☐ Other

Employer: ______ Work Ph: ( )

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Other

Responsible Party: ______ Phone: ( )

Address: ______ City/State/ZIP: ______

Emergency contact: ______ Phone: ( )

Referred By: ______

PRIMARY INSURANCE

Insurance Company Name: ______ Phone: ( )

Claims Address: ______ City/State/ZIP: ______

Subscriber's Name: ______ Date of Birth: / / SSN: ______

Relationship to you: ☐ Self ☐ Spouse ☐ Partner ☐ Dependent ☐ Other:

Subscriber's Address: ______ City/State/ZIP: ______

I.D. No. (***as shown on card***): ______ Group No.: ______

Employer of Insured: ______ Phone: ( )

SECONDARY INSURANCE *OR* AUTO / L & I

Is this visit injury-related? ☐Yes ☐ No Work related? ☐ Yes ☐ No Auto accident? ☐ Yes ☐ No

Insurance Company Name: ______ Phone: ( )

Claims Address: ______ City/State/ZIP: ______

Subscriber's Name: ______ Date of Birth: / / SSN: ______

Relationship to you: ☐ Self ☐ Spouse ☐ Partner ☐ Dependent ☐ Other:

Subscriber's Address: ______ City/State/ZIP: ______

I.D. No. (***as shown on card***): ______ Group No.: ______

Employer of Insured: ______ Phone: ( )

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: ______