NaturaMed
NATURAL FAMILY MEDICINE

8130 North Lake Blvd
P.O. Box 368
Kings Beach, CA 96143
PH: 530-546-0400
Fax: 530-546-0401

Confidential Patient Information

Please fill in all portions of this form printing clearly and legibly to ensure accuracy.

Today's Date: _____

Patient name: _____ Age: _____ Marital Status: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Physical Address: _____ City: _____ State: ____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Birthdate____/____/____AGE:_____ Email:_____

Occupation: _____Employer: _____ Referred by: _____

Work Address: _____ City: _____ State _____ Zip _____

Name of nearest relative not living with you: _____ Phone # _____

Name of spouse (or parent for minor child) _____ SS# _____

Occupation _____ Employer _____ Work # _____

Emergency contact: _____ Relationship _____ Phone: _____

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 fees for professional services rendered me will be immediately due and payable. *Furthermore, any charges, fees or court costs incurred as a result of collection efforts will be added to my account balance*. Permission is hereby given for any medical treatment and any diagnostic procedures required for my health care; or (when a patient is a minor child) for the health care of my minor child.

Examination Policy

This office specializes in the diagnosis and treatment of acute and chronic internal, hormonal, and nutritional conditions. Evaluation is done to determine the nature and extent of your problem. In addition to our in-office evaluation, out-of-office laboratory and/or x-ray evaluation may also be recommended, depending on what is necessary in your case. Your Doctor will explain what tests are necessary or recommended during your consultation with her.

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICES. PAYMENT TODAY WILL BE BY:

CASH _____ CHECK _____ VISA/MC_____

We require 24 hours advance notification of cancellations or changes in appointments, and we reserve the right to charge if sufficient notice is not given.

Patient's signature _____ Date _____

OR:

Printed: _____Signed: _____

(Guardian/Parent signature authorizing care for minor child)