Patient Registration – Mother & Child Natural Medicine

Section 1: Patient Information

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

Date of Birth: _____ Sex:_____ Other names that records may be kept under: _____

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

Home Ph:(_____)_____ Work Ph:(_____)_____ Cell Ph:(_____)_____

Best number to reach you? □ Home □ Work □ Cell Email Contact: _____

May we leave confidential voice-mail messages for you at these numbers? □ No If Yes(specify): **Home Work Cell**

Employer/School: _____

Mother's Name (minors only): _____ Father's Name (minors only): _____

Emergency Contact: _____ Contact's Phone #: (_____)_____

Relationship to Emergency Contact: _____ Do you have special needs?: _____

How did your hear about Dr. Allen?:_____

Section 2: Insurance Information

Insurance Company:_____Member ID number_____Group ID_____

Policy Holder Name:_____**Policy Holder Date of Birth**:_____

Policy Holder Address (if different):_____City/State/Zip_____

Policy Holder Phone Number_____Policy Holder Employer_____

Patient relationship to policy holder: □self □spouse □child □other

Assignment and Release

I certify that I, and/or my dependents(s), have insurance coverage with _____ and I assign directly to Mother & Child Natural Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Mother & Child Natural Medicine may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient or Responsible Party_____ Date:_____

Section 3: Receipt of Policy

Privacy Terms: Mother & Child Natural Medicine (MCNM) keeps a record of the healthcare services she provides you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the records. MCNM will not disclose your medical information to others unless you direct them to do so or applicable laws authorize or compel them to do so. MCNM is required to provide you with a copy of the Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information or our financial policy, contact the office at (425) 333-4600.

I hereby acknowledge that I have received the Notice of Privacy Practices, the Mother & Child Natural Medicine Financial Policy, and the Naturopathic Medicine Informed Consent to treat. I agree to the terms contained within those documents.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Relationship to Patient Date