Hegnauer Holistic Health

Dr. Amanda Hegnauer

Naturopathic Doctor

Patient Information

PATIENT'S NAME_____
(Last) (First) (Middle Initial)

ADDRESS_____
(Street, PO Box)

_____
(City) (State) (Zip Code)

PLEASE CHECK NEXT TO THE NUMBER TO CALL TO BEST REACH YOU:

___Home Phone: ( )_____ ___Day/Work: ( )_____ ___Cell: ( )_____

SOC. SEC #_____-_____-_____ DATE OF BIRTH_____ SEX: M F

MARITAL STATUS: M S D NAME OF PRIMARY CARE PHYSICIAN _____

E-MAIL ADDRESS _____ WOULD YOU LIKE TO RECEIVE OUR NEWSLETTERS VIA

E-MAIL? (We will never share, rent or sell you r information to a third party). Yes No

NAME OF EMPLOYER _____

HOW DID YOU HEAR ABOUT US? _____

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PATIENT AND ACCOUNT)

NAME OF SPOUSE/PARTNER/PARENT _____

PERSON RESPONSIBLE FOR BILL _____

DATE OF BIRTH _____ EMPLOYER _____

PHONE ( )_____ RELATIONSHIP_____

EMERGENCY CONTACT_____ PHONE ( )_____

INSURANCE INFORMATION – WE WILL NEED A COPY OF YOUR CARD

INSURANCE NAME _____

ADDRESS _____
(Street, PO Box) (City) (State) (Zip)

POLICY NUMBER_____ GROUP NUMBER _____

NAME OF POLICY HOLDER _____ RELATIONSHIP _____

POLICY HOLDER EMPLOYER _____ PHONE ( )_____

ADDRESS _____
(Street, PO Box) (City) (State) (Zip)

HMO PATIENTS: DO YOU HAVE A REFERRAL? _____

IS THIS COVERED BY WORKMAN'S COMPENSATION? _____ DATE OF INJURY _____

ADDRESS _____
(Street, PO Box) (City) (State) (Zip)

A CHARGE WILL BE MADE FOR BROKEN APPOINTMENTS UNLESS 24 HOURS NOTICE IS GIVEN