Eclectic Naturopathic Medical Center, LLC

48 Christian Lane ~ Suite 203 ~ Newington, CT 06111

(860) 665-1254

Name_____ Date_____
(Last) (First) (M.I.)

Address_____ Cell Phone_____

City_____ State _____ Zip_____ 2nd Phone _____

Birthday _____ Age _____ Patient's SS #_____

E-mail: _____ Preferred Pronoun She/He/They _____

Single/Married/Other_____# of Children _____

Employed By _____Occupation_____

Name of Spouse/Parent/Partner _____

Occupation _____ Phone _____

Person Responsible for Account _____

Address _____ City_____ State_____ Zip _____

Patients are responsible for submitting claims to their insurance company. Verification will be given to your insurance company should they question your claim.

Type of Insurance_____Insurer's SS # _____ Ins # _____

Referred By _____

Have you seen a Naturopathic Physician Before? _____

If so, when_____ Name of Physician _____

Do you have a Chiropractor? _____Name _____

Have you seen a Nutritionist? _____ Acupuncturist _____Other_____

Do you have a regular Physician?_____Name _____

Are you on any medication? _____Name(s) _____

Main Complaint _____

_____

The patient is responsible for any bills including office visits, supplements, laboratory charges, etc.

I,_____patient or guardian, understand that any bills I incur at this office are my_____ responsibility.* ***Signature of patient or guardian* _____

I,_____ patient or guardian, authorize the attending doctor to release any information _____ regarding my treatment or examination to the above insurance company for the purpose of validating a claim they are processing. ***Signature of patient or guardian***_____