Restorative Health Clinic

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**W e l c o m e  F o r m**

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us-we will be happy to help.

**Personal Information**

Name _____ Today's Date_____
Birth Date _____
Wished to be called_____
Gender: Male Female Status: Minor Single Married Divorced Widowed
Address_____
City_____State_____Zip_____
Phone # _____ Other Phone #_____
Email _____
Employer_____Occupation_____
Referred by_____How did you hear about us?_____

**Other Information**

Pharmacy Name_____
Pharmacy Phone#_____
Primary Physician Name: _____
Primary Physician Phone # _____ Fax# _____
Where do you prefer to receive calls? Home Cell Phone
When is the best time to reach you? Time Days

_____**(your initials)** I give permission for the staff at Restorative Health Clinic to contact me via telephone and leave a message that may contain appointment or medical information if I am not available.

In the event of an emergency, who should we contact?
Name_____Relationship_____
Work#_____Home#_____Cell Phone#_____

**Insurance Information**

**Primary Insurance**

Name of Insured_____Relationship to Patient_____
Insured's birth date_____
Insurance Company_____
Group#_____
ID#_____

**Secondary Insurance (If available)** **Welcome Form Page 2**

Name of Insured_____ Relationship to patient _____
Insurance Company_____
Group#_____
ID# _____

**Responsible Party**

Who is responsible for the account? Name_____
Relationship to patient_____Birth date_____
Address_____
City_____State_____Zip_____
Email_____Home Phone_____Cell_____

**Authorization and Release**

_____**(Initials)** I authorize the release of any information under the HIPA Act, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/ or other health care practitioners.

_____**(Initials)** I understand that the payment for all the services must be done at the time of service and Restorative Health Clinic will not bill my insurance company or it is responsible for any services not cover by my insurance company.

_____**Signature** of patient or parent/ guardian if minor

**Consent for Treatment**

I consent to receive medical care by the licensed health care professionals at Restorative Health Clinic. I understand that all the services rendered are services permitted under the Oregon Naturopathic Doctor License, which may include but are not limited to botanical medicine, hydrotherapy, homeopathy, nutritional supplements and counseling, injections, IV therapy, and prescription drugs included in the OR naturopathic formulary.

_____**Signature** of patient or parent/guardian if minor

_____**Date**