



Restorative Health Clinic

6464 SW Borland Rd. Suite B-2
Tualatin, OR 97062
Telephone: 503-747-2021
Fax: 503-747-2802
www.restorativehealthclinic.com

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# _____

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 HIPAA 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 payment for all services must be done at the time of service and Restorative Health Clinic will not bill my insurance company nor is responsible for any services not covered 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 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