Restorative Health Clinic

6564 SE Lake Rd, Ste 100
Milwaukie, OR 97222
P: 503-747-2021 F: 503-747-2802
www.restorativehealthclinic.com

Welcome Form

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 Code_____

Phone # _____ Other Phone #_____

Email _____

Referred by How did you hear about us?_____

Other Information

Pharmacy Name:_____
Pharmacy Address: _____
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?
Full Name: _____
Relationship: _____
Phone#: _____

Insurance Information

Primary Insurance

Name of Insured: _____
Insured's birth date _____
Relationship to the primary insured: _____
Insurance Company: _____
Group# _____
ID# _____
Insurance Company Phone # _____

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Secondary Insurance

Name of Insured: _____
Insured's birth date _____
Relationship to the primary insured: _____
Insurance Company: _____
Group# _____
ID# _____
Insurance Company Phone # _____

Responsible Party

Who is responsible for the patient's account? _____
Relationship to patient: _____
Address _____
City, State, Zip Code _____
Email: _____
Home Phone # _____ Cell Phone # _____

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. If my doctor bill insurance and services are not covered by it, or my deductible is not met, I will be responsible for any dues.

_____
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