Snohomish Naturopathic Clinic
1101 Avenue D, Suite D103, Snohomish, WA 98290
Phone: 360.568.2686 Fax: 360.862.8016
www.SnohomishNaturopathic.com

*Achieve Optimal Health*

# Patient Registration & HIPAA Acknowledgement

Date _____ Patient Name: Last _____ First_____ MI _____ Nickname _____

## Personal Information

Birthdate_____ Age_____ Male / Female Social Security # _____ Marital Status _____

Address_____ City_____ State_____ Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____ Email: _____

Employer: _____ Occupation: _____ Work Phone ( ) _____

***Please CIRCLE your preferred contact phone number.***

## Billing Information

Person responsible for Bill:
- ☐ Self
- ☐ Spouse
- ☐ Parent
- ☐ Guardian
- ☐ Other: _____

Last Name_____ First_____ MI____ Social Security #_____ Birthdate _____

Address_____ City_____ State_____ Zip_____

Home Phone ( ) _____Work Phone ( ) _____Other Phone ( ) _____

Primary Care Physician (PCP) _____ PCP Phone # ( ) _____

| | | Primary Insurance | Secondary Insurance |
|---|---|---|---|
| | Insurance Company | | |
| | Subscriber Name | | |
| | Subscriber Birthdate | | |
| Fill out only if card is not copied | Insurance Address | | |
| | Insurance ID# | | |
| | Insurance Group# | | |

***Please be sure to give your insurance card(s) to the receptionist so was can make a copy for your file.***

## Emergency Information

Emergency Contact? _____ Relation to Patient? _____ Phone # ( )_____

## Referral Information

Who referred you to our office?

_____

_____

## Preferred Pharmacy

Pharmacy name: _____

Phone #: _____ Fax #: _____

Address _____

**I certify that the above information is true and accurate and accept responsibility for all information provided. I agree that I choose to be seen at The Snohomish Naturopathic Clinic and have complied with the terms of my health coverage program. In the event that my insurance will not cover my services, I acknowledge I must pay for all charges incurred. I authorize The Snohomish Naturopathic Clinic to release any information required to process my claim.**

**I also acknowledge that I have received a copy of Snohomish Naturopathic Clinic's Notice of Privacy Practices.**

_____ _____ _____

Patient Name | Signature of Legally Responsible Party | Date