( ) Karim Abdullah, ND, Lac
( ) Dean Chier, MD
( ) David Deichert, ND, ARNP
( ) Trina Doerfler, DC, ND
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Elizabeth Hughes, MD ( )
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Eva Miller, ND ( )
W. Bruce Milliman, ND ( )
Jane Pemberton, MD ( )
Fernando Vega, MD ( )

PATIENT REGISTRATION

Please fill out completely

First Name: MI: Last Name:

Street Address:

City: State: Zip:

Email: D.O.B:

Employer: Mobile Phone #: ( ) MSG Okay: ( ) YES ( ) NO

Gender Identity: ( ) Male ( ) Female Home Phone #: ( ) MSG Okay: ( ) YES ( ) NO

Work Phone #: ( ) MSG Okay: ( ) YES ( ) NO

Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Dependent ( )Partnered ( )Other

Responsible Party: Phone: ( )

Address: City, ST, ZIP:

Emergency Contact: Phone: ( )

Referred By:

PRIMARY INSURANCE

Insurance Company Name:

Subscriber's Name: **Date of Birth**:

Relationship to you: ( ) Self ( ) Spouse ( ) Dependent ( )Other

I.D. # as shown on card: **Group #:**

SECONDARY INSURANCE

Insurance Company Name:

Subscriber's Name: **Date of Birth**:

Relationship to you: ( ) Self ( ) Spouse ( ) Dependent ( )Other

I.D. # as shown on card: **Group #:**

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assesed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature: **Date:**