Eclectic Naturopathic Medical Center, LLC
66 Cedar Street, Suite 201, Newington, CT 06111
(860) 665-1254

PATIENT REGISTRATION

Name_____ Date_____
(Last) (First) (M.I.)

Address_____ Phone _____

City _____State _____Zip _____ Cell Phone _____

Birthday _____ Age _____ Patient's SS # _____

E-mail: _____ Preferred Pronoun She/He/They_____

Single/Married/Other _____ # of Children _____

Employed By _____ Work Phone (___) _____

Occupation _____

Name of Spouse/Parent/Partner _____

Person Responsible for Account _____

Address _____ City _____ State _____

Patients are responsible for submitting claims to their insurance company. Verification will be given to your insurance company should they question your claim.

Type of Insurance _____ Insurer's SS # _____ Ins # _____

Referred By _____

Have you seen a Naturopathic Physician before? _____

If so, when _____ Name of Physician _____

Do you have a Chiropractor? _____ Name _____

Have you seen a Nutritionist? _____ Acupuncturist _____ Other _____

Do you have a regular Physician? _____ Name _____

Are you on any medication? _____ Name(s) _____

Main Complaint _____

_____

The patient is responsible for any bills including office visits, supplements, laboratory charges, etc.

I, _____ patient or guardian, understand that any bills I incur at this office are my responsibility.* ***Signature of patient or guardian* _____

I, _____ patient or guardian, authorize the attending doctor to release any information regarding my treatment or examination to the above insurance company for the purpose of validating a claim they are processing. ***Signature of patient or guardian*** _____