



**CONFIDENTIAL PERSONAL INFORMATION**

Full Legal Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

Preferred Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ / (\_\_\_\_) \_\_\_\_\_ / (\_\_\_\_) \_\_\_\_\_  
(Home) (Cell) (Work)

Address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Street/PO Box) (City) (State) (Zip Code)

E-mail address: \_\_\_\_\_ Gender: female \_\_\_\_\_ male \_\_\_\_\_

Live with: Alone \_\_\_\_\_ Spouse \_\_\_\_\_ Partner \_\_\_\_\_ Family \_\_\_\_\_ Housemate \_\_\_\_\_ Other \_\_\_\_\_

Occupation: \_\_\_\_\_ (circle) Full time Part time Student Retired

Employer/School: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
(Name) (Relationship)

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
(Day Phone) (Evening Phone)

Do you have a family member/friend as patient of this center? \_\_\_\_\_ Name? \_\_\_\_\_

How did you hear about this center? \_\_\_\_\_

May we contact you regarding health-related events at the Sacramento Naturopathic Medical Center? Yes, please \_\_\_\_\_ No, thank you \_\_\_\_\_

**Financial Policies**

We are fully committed to providing you with excellent and affordable health care and with the very best service humanly possible. We will not rest until we do so. The following financial policy is designed to help us continue doing so.

- Charges are to be paid at the time of the visit unless arrangements have been made PRIOR to the visit.
- If you miss an appointment or cancel less than 24 hours, you will be billed for half of the consultation fee for each occurrence.

As the patient, you are responsible for the total charges incurred for each visit. We accept cash, checks, Visa, Master and American Express cards. There will be a charge of \$25 for a returned check. I have read and understand the above-stated policies and I agree to these conditions. I sign below to also agree that in order to ensure the highest quality of health care, SacND physicians may discuss my case with other practitioners.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_