FAMILY CLINIC OF NATURAL MEDICINE

Patient Information

Thank you for choosing the Family Clinic of Natural Medicine!

Please print. All information is kept confidential

Date_____________ Last Name___________________ First Name___________________ MI_______

Age_________ Date of Birth_________________ Gender M/F

Address____ City____________________________

State_____________ Zip _______________

Home Phone__________________ Cell Phone_________________ Work Phone__________________

Email__________________________________

It is okay to call or leave a message from the clinic at (circle all that apply) Home Cell Work

Occupation __________________________________ Employer ___________________________

Circle appropriate status: Minor Single Married Divorced Widowed Separated

Spouse/Parent/Guardian Name __________________________ Phone Number_______________

Emergency contact ____________________________________ Phone Number _______________

Whom may we thank for referring you to us? ____

CONSENT FOR TREATMENT

I am requesting and hereby authorize services offered to me by Dr. Aaron Henkel or Dr. Rebecca Georgia including physical examination, specialized tests, and treatment deemed appropriate by my provider. As a patient, I am to be fully informed of benefits and possible complications, as well as alternatives to the proposed treatment, including no treatment.

I understand that I am responsible for all fees at the time of service, regardless of insurance coverage or treatment outcome. I recognize that the doctors are licensed naturopathic doctors in the state of Washington or Minnesota, and that he/she have been trained to act on my behalf as a primary care, general practice physician. I am aware that in the state of Wisconsin, there is no licensure regulating the practice of naturopathic medicine, therefore clinical diagnosis may not be made.

FCNM requires a 24 hour cancellation notice for all appointments

I confirm that I have read and fully understand the above prior to my signing

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Signature of Patient (Parent or Guardian if patient is minor) Date