Area's marked in ***Italics*** must be filled out.

Eclectic Naturopathic Medical Center, LLC
Kathleen M. Riley, ND
2434 Berlin Turnpike ♣ Suite 18 ♣ Newington, CT 06111
(860) 665-1254

PATIENT REGISTRATION

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

Address_____ Phone ( )_____

City _____State _____Zip _____Cell Phone ( )_____

Birthday _____ Age _____ Male ☐ Female ☐ # of Children ____

Patient's SS # _____E-mail: _____

Employed By _____ Work Phone ( )_____

Occupation _____ Single☐ Married ☐ Other _____

Name of Spouse/Parent/Partner _____

Occupation _____ Work Phone ( )_____

Person Responsible for Account _____

Address _____ City _____ State _____

****Patients are responsible for submitting claims to the insurance company. Verification will be giving 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*** _____