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

***Eclectic Naturopathic Medical Center, LLC***
***Kathleen M. Riley, ND & Dr. Susan Yarett, N.D.***
***48 Christian Ln ♣ Suite 203 ♣ 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 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*** _____