NW Integrative Medicine Clinic
509-516-1208
1029 N Kellogg St
Kennewick, WA 99336

PATIENT REGISTRATION

Today's Date: _____ Birthdate: _____

Patient Name: _____

Single Married Divorced Widowed Other

Home Phone: _____ Cell: _____ Gender: M F

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ (Dr. Smith periodically sends updates via email)

Employer: _____ Occupation: _____

Business Address: _____ Phone: _____

****Please note that we are not contracted with any Insurance at this time. We are not a Medicare provider and are not contracted with any State Funded policies.**

Name of Insurance: _____

Group#: _____ Membership ID: _____

Policy Holder Name: _____ Birthdate: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Who may we thank for referring you to our office?: _____

Consent to treat: I understand by signing below I consent to medical treatment performed by Stephen L Smith, MD and his staff. I understand that no guarantee has been made regarding results of such treatment.

_____ _____ _____

Signature of Patient or legally authorized individual Date Relationship to Patient if signed on behalf