



PATIENT INFORMATION

For your safety and quality of care, please print all information CLEARLY.

Today's Date: _____

PATIENT INFORMATION

| | | |
|---|---|--------------|
| Last Name: | First Name: | Middle Init: |
| Male <input type="checkbox"/> Female <input type="checkbox"/> | Birth Date (MM/DD/YYYY): Current Age: | |
| Street Address: | City, State, Zip: | |
| Preferred Telephone #: This is home <input type="checkbox"/> work <input type="checkbox"/> mobile <input type="checkbox"/> OK to leave confidential voicemail: yes <input type="checkbox"/> no <input type="checkbox"/> | Alternate Telephone #: This is home <input type="checkbox"/> work <input type="checkbox"/> mobile <input type="checkbox"/> OK to leave confidential voicemail: yes <input type="checkbox"/> no <input type="checkbox"/> | |
| Email: <input type="checkbox"/> I do not wish to be on the clinic e-mailing list | How did you hear about Dr. Epstein? Patient Referral, by: Health Provider Referral, by: Other: | |

EMPLOYMENT INFORMATION

| | |
|--|-------------------------------|
| Employer or School: Since when: | Occupation or field of study: |
| <input type="checkbox"/> Currently unemployed <input type="checkbox"/> Self-employed <input type="checkbox"/> Somebody else in the home is the breadwinner | |

EMERGENCY CONTACT INFORMATION

| | |
|---|---|
| Person to contact in case of emergency: | Their relationship to me: |
| Telephone #: This is home <input type="checkbox"/> work <input type="checkbox"/> mobile <input type="checkbox"/> | Alternate Telephone #: This is home <input type="checkbox"/> work <input type="checkbox"/> mobile <input type="checkbox"/> |
| 2nd Emergency Contact (optional): | Their relationship to me: |
| Telephone #: This is home <input type="checkbox"/> work <input type="checkbox"/> mobile <input type="checkbox"/> | Alternate Telephone #: This is home <input type="checkbox"/> work <input type="checkbox"/> mobile <input type="checkbox"/> |

I understand that I am responsible for all charges incurred, and agree to pay all charges **at the time of service**, unless other arrangements have been approved by and made with Dr. Epstein *in advance* of the service rendered. I understand that Lumina Health Naturopathic Medicine may, at my request, provide me with a receipt that I may submit to my insurance carrier if I so choose, and I understand that my insurance carrier will not be billed directly by Lumina Health on my behalf.

Signature: _____ Date: _____

Name/Relationship of person signing if patient is unable to, or under 18: _____