



NCNM Community Clinic Patient Registration

Patient's Legal Name:

First Middle Last

The information you provide helps us to serve you and other members of the community, and assists us to help you reach your health goals. Please write legibly and answer all questions.

What is your preferred name? (nickname, chosen name, etc) _____

Social Security Number: _____ Birth date: _____

What is your birth sex? Male Female Other (specify) _____

What gender do you identify as? Male Female Other (specify) _____

What is your preferred pronoun? He She Other (specify) _____

Address: _____

City: _____ State: _____ Zip code: _____

Contact information (please circle preferred number for contacting you):

Home phone: _____ Work phone: _____

Cell phone: _____ Email address: _____

Primary Language: _____ Interpreter Needed? Yes No

Currently Homeless? Yes No At Risk for Homelessness? Yes No

Agricultural Seasonal/Migrant Worker? Seasonal Migrant Neither US Veteran? Yes No

Ethnic Group (Select one): Hispanic Non-Hispanic

Race (You can select more than one):

Native Alaskan Native Hawaiian Pacific Islander American Indian

Asian Black White

Occupation: _____ Hours per week: _____

Employer: _____ Address: _____

City: _____ State: _____ Phone: _____

Employment status (Check one): Full Time Part Time Retired Seasonal

Self-Employed Student (Full Time) Student (Part Time)



Emergency contact:

Name: _____

Relationship to the patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Legal Guardian? Yes No

Guarantor: Who is financially responsible for this appointment?

Name: _____ Relationship to the patient: _____

Address: (if different from self) _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Gender: M F Birth Date: _____

Home Phone: _____ Work Phone: _____

Guarantor Language: _____

Household annual income: _____ Family Size (including self): _____

I certify that the above information is true and correct to the best of my knowledge.

Signature: _____

Date: _____

Consent for Treatment

I understand that my care as a patient at the National College of Natural Medicine (NCNM) is directed by supervising staff physicians, licensed acupuncturists, and/or other licensed professionals. I consent to services rendered and provided to me under the instructions of these professionals assisting in my care, as well as volunteer staff physicians who may be associated for the purpose of consulting.

I recognize that NCNM is a teaching institution. I agree that persons who are students and resident physicians may participate in my care as part of the educational programs of the institution.

By checking this box, I give permission for my health data to be used **anonymously** for research purposes.

I have fully read and understand the above agreements and authorizations.

Sign Patient (18 years or older)

Date

Print Name Patient (18 years or older)

Sign Parent, Guardian, Responsible Party

Date

Print Name Parent, Guardian, Responsible Party

**STATEMENT OF FINANCIAL RESPONSIBILITY
DECLARACIÓN DE RESPONSABILIDAD FINANCIERA**

I understand and agree to the following general responsibilities:

Entiendo y estoy de acuerdo con las responsabilidades generales siguientes:

- Financial options are extended to me based on the information I have provided.

Las opciones financieras me han sido ofrecidas en base a la información que he proporcionado.

- I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service (unless payment arrangements have been made), including Medicinary, lab work and tests, and physician ordered add-on lab work and tests.

En calidad de fiador(a) del paciente (o de la paciente), me hago responsable del pago completo de los servicios recibidos a la hora de prestarse (a menos que se hayan tomado medidas del pago), incluyendo medicinas, mano de obra, pruebas de laboratorio y pedidos médicos de pruebas de laboratorio.

- I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving.

Me hago responsable de proporcionar toda la documentación exacta y completa necesaria para soportar cualquier descuento que esté recibiendo.

- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the NCNM Community Clinic to release information necessary to secure payment.

Reconozco que me hago financieramente responsable de todos los gastos. Si se hace necesario recaudar cualquier cantidad adeudada en la visita actual o visitas siguientes, el signatario abajo se compromete en pagar todos los costos y gastos, incluyendo honorarios razonables de abogado.

Mediante la presente autorizo a la Clínica Comunitaria de NCNM a hacer disponible la información necesaria para garantizar el pago.

I have fully read and understand the above agreements and authorizations.

He leído este documento en su totalidad y comprendo los acuerdos y autorizaciones mencionadas.

Patient (18 years or older)
Paciente, de por lo menos 18 años de edad

Date
Fecha

Parent, Guardian, Responsible Party
Padre, madre, tutor, persona responsable

Date
Fecha