NOR CAL Natural Medicine
June E. Stevens ND
1135 Pine Street, Suite # 112
Redding, CA 96001
Phone: (530) 691-4115
Fax: (530) 691-4116

How did you hear of us?
Internet: ___Radio/TV: ___Sign:___ Lecture___ Family/Friend___ Name:_____
Were you referred by another Health Care Provider___ Yes ___ No
If "Yes", please provide referring Physicians name: _____

Patient Demographics

Name: _____ Sex: ____ Gender_____ Date of Birth: _____
Address: _____ City: _____ St: _____ Zip: _____
Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____

Additional Patient Information

Today's Date: _____ Primary Care Physician: _____
Employer: _____ Occupation: _____
Work Address: _____ City: _____ St: _____ Zip: _____
Name of nearest relative not living with you: _____ Relation: _____Phone: _____
Material Status (circle): Single Married Separated Divorced With Partner Widow(er)
Name of Spouse/Significant Other: _____
Whom may we contact in an emergency: _____ Relation: _____
Emergency Contact #: (____) _____

Insurance Information (Please provide card for Coping)

Insurance Company: _____ Phone: _____
Name of Insured: _____ Relationship to Insured: _____
S.S.#: _____/_____/_____ Policy #: _____ Group#: _____

Insurance Information

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Furthermore, in the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to the maximum of 50% of our outstanding balance at the time the account is placed with the agency. Should legal action also be necessary to collect the account, I/we agree to pay attorney's fees and court costs incurred for the collection. Releases may be requested prior to specific procedures being performed (i.e., minor surgery, etc.)

Clinic Policy requires full payment at the time of services

Patient's Signature_____ **Date**_____