HUDSON
NATUROPATHIC CLINIC

PATIENT PROFILE

I. Patient Information

Name of patient: _____ Age: _____
Parent or legal guardian (*if a minor*): _____
Mailing address: _____ City: _____
State: _____ Zip Code: _____ Email address: _____
May we email you important health updates? Yes/No (*circle*)
Birth date: _____/_____/_____ Sex: Male Female (*circle*)
Marital status: Single ____ Married ____ Widowed ____ Separated ____ Divorced ____ (*check*)
Home phone: ( ) _____ May we call & leave messages at this number? Yes/No (*circle*)
Work phone: ( ) _____ May we call & leave messages at this number? Yes/No (*circle*)
Cell phone: ( ) _____ May we call & leave messages at this number? Yes/No (*circle*)
When is the best time to reach you? _____
Occupation: _____ Full Time? Yes/No (*circle*)
Employer/School: _____
Employer/School Address: _____
How did you hear about Dr. Hudson? _____
Current health care team:
Primary care physician: _____ Surgeon: _____
Acupuncturist: _____ Chiropractor: _____
Other: _____

II. Spousal/Partner Information

Spouse's/Partner's name: _____ Birth date: _____
Spouse's/Partner's occupation: _____ Spouse's/Partner's employer: _____

III. Who to Contact in Case of Emergency

Name: _____ Relationship: _____
Home phone: _____ Work phone: _____Cell: _____

IV. Responsible Party

Name of person responsible for account (*if other than patient*): _____
Relationship to patient: _____
Address: _____
Home phone: _____ Work phone: _____ Cell: _____

V. Insurance Information

Is the patient insured? Yes/No (*circle*)
Insurance Company: _____
Subscriber Name: _____ Relationship to patient: _____
ID#: _____ Group #: _____

I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____
Responsible Party Signature Date