HUDSON
NATUROPATHIC CLINIC

PEDIATRIC PATIENT PROFILE

I. Patient Information

Name of patient: _____ Age: _____
Parent/Responsible party: _____
Mailing address: _____ City: _____
State: _____ Zip Code: _____ Email address: _____
May we email you important health updates? Yes/No (*circle*)
Birth date: _____/_____/_____ Sex: Male Female (*circle*)
Home phone: ( ) _____ May we call & leave messages at this number? Yes/No (*circle*)
When is the best time to reach you? _____
School Address: _____ School Phone Number: _____
How did you hear about Dr. Hudson? _____
Current health care team:
Pediatrician: _____ Dr. Phone Number: _____
Specialist Doctor: _____ Dr. Phone Number: _____
Specialist Doctor: _____ Dr. Phone Number: _____

II. Who to Contact in Case of Emergency

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

IV. Responsible Party

Name of person responsible for account: _____
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