

*Naturopathic Family Medicine*  
*6501 SE King Road*  
*Milwaukie, Oregon 97222*  
*Patient Intake Form*

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Sex: Male Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employers Address: \_\_\_\_\_

Marital Status:      Single      Married      Partnered      Divorced

**If you would like Naturopathic Family Medicine to bill your insurance plan, please provide the following information:**

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Phone #: \_\_\_\_\_ Extension: \_\_\_\_\_

Address to submit claims: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Are you seeking health care advice from any other physicians or practitioners? \_\_\_\_\_**  
**If yes, please list their name, phone and address:**

In case of Emergency, Please Notify:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_