PATIENT INFORMATION

Thank you for choosing the **Center for Natural Medicine** to provide your health care.
Please print. All information will be kept confidential.

Date ________________ Last Name _________________________ First Name ____________________ MI _____

SSN _____________________ Age _________ Date of Birth ________________ Birth Gender ______________

Address _____________________________ City ____________________ State _____ Zip Code ______________

Home phone ____________________ Cellular phone _____________________ Work phone ____________________

It is acceptable to leave messages from the clinic at (check all that apply) : ❑ Home ❑ Cellular ❑ Work

Check appropriate box: ❑ Minor ❑ Single ❑ Partnered ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Occupation __________________________________ Employer / School ___________________________________

Spouse or parent's name __________________________________ Phone number _________________________

Whom may we thank for referring you? ____

Person to contact in an emergency __________________________________ Phone _________________________

CONSENT FOR TREATMENT

I am requesting and hereby authorize services offered to me by Dr. Ruddy and/or Dr. Nancy Gutknecht and/or Dr. Sara Fleming and/or Dr. Allison Becker including physical examination, specialized tests, and treatment deemed appropriate by my provider. As a patient, I am to be fully informed of benefits and possible complications, as well as alternatives to the proposed treatment, including no treatment.

I understand that I am responsible for all fees at the time of service, regardless of insurance coverage or treatment outcome.

I recognize that the doctors are licensed naturopathic doctors in the states of Vermont, Oregon and Washington and that they have been trained to act on my behalf as a primary care general practice physicians. I am aware that in the state of Wisconsin, there is no licensure regulating the practice of naturopathic medicine, therefore clinical diagnosis may not be made.

CNM requires a 24 hour cancellation notice for all appointments. Missed appointments will be charged a $60.00 cancellation fee.

I confirm that I have read and fully understand the above prior to my signing.

____ _________________________

Signature of Patient (Parent or Guardian if patient is a minor) Date

Center for Natural Medicine
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Middleton, WI 53562

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fax 608-441-1593