Dr. Angela Loise Wojtowicz, N.M.D.
info@naturalhealingcarecenter.com
(520) 323-0069
2272 E Speedway Blvd, Tucson, AZ 85719

Confidential Patient Information

Patient Contact Information

Name:_____ _____ _____/_____/_____

(Last) (First) (Sex) (Date of Birth)

Permanent Address: _____ City: _____ State: _____ Zip: _____

Temporary Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Phone Work: _____

Email Address: _____

Name of nearest relative not living with you: _____ Relation:_____

Phone: _____

Additional Patient Information

Today's Date: _____/_____/_____

Employer:_____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

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Whom may we contact in case of an emergency: _____ Relationship to you: _____

Emergency Contact Phone #: _____

How did you hear of us? _____

Were you referred by another physician: ❑ Yes ❑ No

If "Yes" please provide us with as much information as possible for the Referring Physician?

Referring Physician's Name:_____

Address, City, State, Zip: _____

Telephone Number: _____

Insurance Information

Insurance Company: _____ Phone: _____

Name of Insured: _____ Relationship to the Insured: _____

Policy #: _____ Group #: _____

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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 at the time of service. 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 place with a licensed collection agency, I/we agree to pay the fees of the collection 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 payment at time of services.

Signatures

_____ _____ ____/____/____

Patient's Signature **Parent or Guardian's Signature** **Date**