

Hello and Welcome

Thank you for choosing Naturopathic Wisdom. We know you have choices when it comes to your healthcare and we are dedicated to providing our patients with the best care possible.

Enclosed you will find new patient forms. Before your scheduled appointment, please carefully read and fill out the enclosed forms. We know your time is valuable and bringing your completed patient information forms with you will maximize the amount of time spent with the doctor.

Your first visit will be an assessment of your health lasting approximately 1 hour or more. The fee varies and is based on time; feel free to call the office if you need more information.

If you are unable to keep your scheduled appointment time please call as soon as possible so that we may reschedule your visit.

Remember to bring copies of any recent lab work or medical records as well as any supplements or medications you are currently taking.

We look forward to supporting you in your healing journey.

In Health,

Naturopathic Wisdom

Naturopathic Wisdom
David Hogg, ND

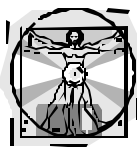
Name _____

Date __/__/__

General Intake Form

1. What are your expectations of the first visit?
2. What are your expectations of me in the first visit?
3. What are your expectations of the time it will take to recover your health?
4. Is there anything you will not do or change?
5. What is your commitment level 0-10 to your recovery? Why?
6. What obstacles do you see to achieving optimal wellness?
7. Who do you have to support you through recovery?
8. What do you see that you do everyday that supports or diminishes your wellness?
9. What is your lifestyle?
10. What is your typical day-to-day schedule?

Naturopathic Wisdom



CONFIDENTIAL PATIENT INFORMATION

PLEASE FILL IN ALL PORTIONS OF THIS FORM. IF YOU NEED HELP, PLEASE ASK

Today's Date _____

How did you hear about us? Yellow pages _____ Newspaper _____ Radio/Television _____
Internet _____ Location/Sign _____ Referred by (name) _____
Bay Area Naturally _____ Whole Foods (name) _____

Name of Patient _____ Age _____ Marital Status _____

Permanent Address _____ Apt. _____ City _____ State _____ Zip _____

Temporary Address _____ Apt. _____ City _____ State _____ Zip _____

Phone (Permanent) _____ (Cell) _____ (Work) _____

Email _____ Email (alt.) _____

SS# _____ Birth date _____ Sex _____ Driver's License # _____

Occupation _____ Employed by _____

Work Address _____ City _____ State _____ Zip _____

Name of nearest relative not living with you _____ Phone _____

Name of spouse (or parent for minor child) _____ SS # _____

Occupation _____ Employed by _____ Work # _____

Whom may we contact in case of emergency? _____ Phone _____

CLINIC POLICY REQUIRES PAYMENT AT TIME OF SERVICES. I WILL BE PAYING TODAY BY:

CASH _____ CHECK _____ VISA _____ MASTERCARD _____

At time of payment, you will be given a copy of your superbill from our office. This will show the services and charges for that day.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and services, any fees for professional services rendered me will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance.

Releases may be requested prior to specific procedures being performed

Patient's Signature

Parent or Guardian's Signature

Date