

Corina B. Going, ND

3402 6th Avenue • Tacoma, Washington 98406 • (253) 341-9410

PATIENT PROFILE

Please Print Clearly in Black or Blue Ink

Today's date _____
Patient Name _____ Birthdate _____
Patient Gender M / F Parent's name (if patient a minor) _____
Address _____
City _____ State _____ Zip _____
Home phone _____ Work phone _____
Other phone _____ Email: _____
Occupation _____
Employer _____

In case of emergency, please contact:

Name _____ Phone _____

Relationship _____

INSURANCE INFORMATION

Please Print Clearly in Black or Blue Ink

Primary Insurance

Insurance Company Name _____
Insurance Company Address _____
Name of policy holder _____ Birthdate of policy holder _____
Relationship of patient to policy holder: self / spouse / child / other
Policy holder's ID number _____ Policy holder's employer _____
Policy number _____
Policy holder's plan, group or program name _____

Secondary Insurance

Insurance Company Name _____
Insurance Company Address _____
Name of policy holder _____ Birthdate of policy holder _____
Relationship of patient to policy holder: self / spouse / child / other
Policy holder's ID number _____ Policy holder's employer _____
Policy number _____
Policy holder's plan, group or program name _____

OTHER INFORMATION

If automobile or work related accident, please give the date of the injury. _____

What other health care are you presently receiving? _____

How did you hear about this clinic? _____

PRESENT HEALTH CONCERNS: In your opinion, what are your most important health concerns in their order of significance? Please indicate the problem that motivated you to come in today.

1) _____

2) _____

3) _____

4) _____

5) _____

Please read this before signing.

*I understand Dr. Going may submit billings and prepare necessary reports and forms to assist in collection from the insurance carriers on my behalf and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me **may** be charged directly to me within the limits of the provider contract my doctor may have with my insurance carrier, and that I am personally responsible for payment for any balance due.*

Accounts not paid in full within 30 days are considered past due and will be subject to a \$5 rebilling charge per month.

I also understand that if I suspend or terminate my care and treatment, any outstanding fees for services and products rendered me will be immediately due and payable

I authorize the release of any medical information necessary to process my insurance claims and I authorize payment of medical benefits to the supplier of services described on claims submitted on my behalf.

Patient's signature _____ Date _____

Guardian or Spouse's

Signature authorizing care _____ Date _____