Corina B. Going, ND
3402 6th Avenue • Tacoma, Washington 98406 • (253) 341-9410

PATIENT PROFILE

Today's date ________________
Patient Name ____ Birthdate _______________
Patient Gender __________ Preferred Pronouns ______________________
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 your 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.

I verify that the information on this form is true and accurate to the best of my knowledge.

Name of Person Completing Form: ____

Date: ______________________________________