



# Corina B. Goíng, ND, PLLC

Naturopathic Physician ♦ Classical Homeopath

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(253) 341-9410

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## PATIENT PROFILE

Today's date \_\_\_\_\_  
Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Preferred Gender \_\_\_\_\_ Gender at Birth \_\_\_\_\_ 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 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) \_\_\_\_\_