

Heidi Peterson, N.D.



4444 SW Corbett Ave, Portland OR 97239 \_ 503-224-2590 \_ 503-224-2592 (fax)

**Patient Information**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB \_\_\_\_\_

SSN: \_\_\_\_\_ Gender: Male / Female

Occupation: \_\_\_\_\_ #hrs worked per week: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_ Please circle numbers where we can call  
and leave messages.

Email: \_\_\_\_\_

Check box if you want to be contacted via email.  
**EMAIL IS NOT APPROPRIATE FOR URGENT QUESTIONS.**

**Emergency Contact:** \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_

If you would like to authorize a partner or other person to be able to discuss your health or billing information with us, please list them below. I.e. – if you want your spouse to get your lab results or research a billing issue.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Whom can I thank for this referral?** \_\_\_\_\_

**Authorization to Treat (please initial below)**

\_\_\_\_\_ I authorize Heidi Peterson, ND to examine and treat me.

\_\_\_\_\_ I understand that treatments and therapies recommended by Heidi Peterson, ND  
may be different than those offered by other licensed health care providers and I  
am at liberty to seek other care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_