Heidi Peterson, ND
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PATIENT INFORMATION

Name ______________________ Age __________ Date of Birth __________

SS ______________________ Gender: ☐ Male ☐ Female

Occupation ______________________ No. hrs. worked per week: __________

Address ______________________ City/State __________ Zip __________

Contact phone ______________________ ☐ Home ☐ Work ☐ Mobile

Email*______________________

What is your preferred method of contact? ☐ Phone ☐ Email* Okay to leave message? ☐ Yes ☐ No

*Please note that email is not appropriate for urgent questions.

Emergency contact ______________________ Relationship __________

Emergency contact phone ______________________ ☐ Home ☐ Work ☐ Mobile

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 (e.g., if you want your spouse to get your lab results or research a billing issue.)

Name ______________________ Relationship __________

Whom may 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 __________