



Heidi Peterson, ND

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PATIENT INFORMATION (PEDIATRIC)

Name _____ Age _____ Date of Birth _____

SS _____ Gender: Male Female

Parent / Guardian: _____

Parent / Guardian: _____

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 child's health or billing information with us, please list them below (e.g., if you want your spouse to get your child's 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 my child.

_____ 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 for my child.

Signature of Guardian: _____ Date _____