

JAM NATUROPATHICS

4759 Cornell Road, Suite D, Cincinnati, Oh 45241-2432 Phone 513-489-9329 FAX 513-489-9354

Client Information

Name _____
(Last, First, Middle Initial)

Social Security # _____ Home Phone _____ Work Phone _____

Address _____ City, State, Zip _____

Date of Birth _____ Age _____ Height _____ Weight _____ Shoe Size Left _____ Right _____

Place of Birth City _____ State _____ Country _____

Employer _____ Occupation _____

Employer 's Address _____ City, State, Zip _____

Are you employed by any City, State or Federal Government or Regulatory Agency Yes No

If yes, whom _____

Spouse's Name _____ Home Phone _____ Work Phone _____

Family Physician _____ Phone _____

In Case of Emergency, notify _____ Relationship _____

Address _____ City, State, Zip _____ Phone _____

Whom may we thank for referring you to this office _____

Please Read and Sign

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment on receipt of said services. In case of coverage by health insurance, worker's compensation, or auto accident, I agree to pay this office directly and have the insurance company reimburse me, unless prior arrangements are made and approved by this office.

This office will not be held responsible for pre-existing medically diagnosed conditions nor for any medical diagnosis.

Cancellation Policy: The time of your appointment is reserved for you. **Please give us 24 hours notice if you are unable to keep the scheduled time. If you cancel with less than the 24-hour notice, JAM Naturopathics reserves the right to charge you for a standard appointment (\$50.00).**

I have read and fully understand this form.

Signature _____ Date _____

