



Please fill out only the highlighted areas

Patient's Name (Please print): _____

Phone # _____ OK to leave detailed message? yes no

Date of Birth: _____ Gender: (Male /Female)

Marital Status: M S D P Employer: _____

Primary Insurance Information

Insurance Company _____ Phone # _____

Insured ID# _____

Group# _____

Your relationship to insured: Self _____ Spouse _____ Child _____ Other (specify) _____

Insured's Name: _____ Gender: (Male / Female)

Date of Birth: _____

Marital Status: M S D P

Employer: _____

Below Line For Office Use Only

____ New Patient _____ New Insurance Only

Dr. _____ Appt Date: _____

Carrier Name: _____

Claims Mailing Address (if not on card): _____

Insurance Effective Date: _____ **Network Used:** _____

Benefit Limit: _____ **Combined :** yes no

Naturopathic Coverage-

PP: Co-Pay or _____ % Deductible _____ **NPP:** Co-Pay or _____ % **Deductible** _____

Please specify any exclusions, referral requirements, etc. _____

Acupuncture Coverage-

PP: Co-Pay or _____ % Deductible _____ **NPP:** Co-pay or _____ % **Deductible** _____

Please specify any exclusions, referral requirements, etc. _____

Lab Coverage-

Covered if ordered by ND yes no Does Deductible Apply yes no

1st Call Date: _____ 2nd Call Date: _____ 3rd Call Date: _____

Talked With: _____ Talked With: _____ Talked With: _____

Your Initials: _____ Your Initials: _____ Your Initials: _____



Secondary Insurance Coverage Information

Patient's Name (Please print): _____

Insurance Company _____ Phone # _____
Insured ID# _____
Group# _____

Your relationship to insured: Self _____ Spouse _____ Child _____ Other (specify) _____

Insured's Name: _____ **Gender:** (Male / Female) _____

Date of Birth: _____

Marital Status _____ Employer: _____

Below Line For Office Use Only

Carrier Name: _____

Claims Mailing Address (if not on card): _____

Insurance Effective Date: _____ **Network Used:** _____

Benefit Limit: _____ **Combined :** ___yes ___no

Naturopathic Physician Coverage-

PP: Co-Pay or _____% Deductible _____ **NPP:** Co-Pay or _____% **Deductible** _____

Please specify any exceptions, referral requirements, etc. _____

Acupuncture Coverage-

PP: Co-Pay or _____% Deductible _____ **NPP:** Co-pay or _____% **Deductible** _____

Please specify any exceptions, referral requirements, etc. _____

Lab Coverage-

Covered if ordered by ND ___yes ___no Does Deductible Apply ___yes ___no

1st Call Date: _____ 2nd Call Date: _____ 3rd Call Date: _____

Talked With: _____ Talked With: _____ Talked With: _____

Your Initials: _____ Your Initials: _____ Your Initials: _____