Patient Registration

Olympia Natural Medicine
Dr. Karyn White

Patient_____
Last Name First Name MI

Home phone ( )_____Cell( )_____Work( )_____

Preferred Pronoun:_____

Responsible party (If Minor)_____

Street Address_____ Email Address_____

City_____ State_____ Zip Code_____

Gender_____ Date of Birth_____

It is okay to leave appointment reminders & messages containing medical information on your:

Home ____Work_____ Cell_____ Check all that apply

Name of Primary Physician_____

Do you have Medical Insurance Yes _____No_____ Medicare Yes _____ No _____

Name of Primary Insurance_____ Policy Holder_____

Name and gender used for insurance billing_____

Subscriber #_____Group#_____

In case of emergency, who should we contact?_____ Relationship_____

Phone#_____

Authorization: Insurance Acknowledgement & Release

I certify that I have insurance with _____ and assign directly to Karyn N White ND all insurance benefits if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from date of signed below.

_____
Signature and printed name of Beneficiary, Guardian, or Personal Representative Date signed

Revised 3.9.2018