

Dr. Chris Booren, Naturopathic Physician
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Patient Information

Personal

Last Name _____ First Name _____ Middle Initial _____

Home Address _____

City _____ ST _____ Zip _____

Primary Phone _____ Secondary Phone _____

Email Address _____

May we use your email address to communicate with you regarding newsletter, product promotion and general health information? Yes / No (please circle)

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

Social Security Number _____

Emergency Contact Name _____ Phone No _____

How did you hear about my practice?

Referral _____ Phone Book _____ Insurance Co _____ Other _____
If by referral, please let us know their name so we can say "thank you". _____

Employment

Company Name _____

Work Phone _____

What is your job? _____

Insurance

Do you have insurance? Yes / No (please circle)

If yes, name of insurance company _____

Member or Subscriber ID _____ Group _____

Please provide us with your insurance card to photocopy.

Patient's Signature _____ Date _____

Legal Guardian's Signature _____ Date _____