Three Rivers Ayurveda, Inc.

New Patient Forms

Name (Last, First, MI):____

Date of Birth (MM/DD/YYYY):____

Social Security: _______ - ______ - ________

How do you prefer to be addressed? (Please Circle): Ms. Mr. Mrs. Dr. First Name

Mailing Address:

____

City: ___________________________________ State: _____________ Zip Code: __________

Shipping Address (if different):

____

City: ___________________________________ State: _____________ Zip Code: __________

Home Phone: (_______) -_____________
Cell Phone: (_______) -_____________
Work Phone: (_______) -_____________
Fax: (_______) -_____________

Do I have your permission to leave any messages on: Day Phone? (Circle): YES NO

Do I have your permission to leave any messages on: Evening Phone? YES NO

Email: ____
Employer: ____
Occupation:____

Nearest Relative: _____________________________ Phone: ______________________________

Physician: ___________________________________ Date of last Physical: _________________

Dentist: ____________________________________ Date of last Visit: ____________________

Name of Medical Insurance: ____

Whom to contact in case of an emergency:

____

____

Who referred you to the Clinic: ____

Acknowledgement

I acknowledge full responsibility for the payment of services and agree to pay for them, in full, at the time of service unless other arrangements have been made with the office in writing.

Patient's or Guardian's Signature: ____

Patient's Name (Please Print): ____

Credit Card Authorization

I give my permission to Three Rivers Ayurveda, Inc., to keep my credit card on file. This card is to be used only when I approve the charges and in the event of appointment cancellations 48 hours or less before the time of the appointment.

CC# _______________________________________ Exp. ______________ CVV#___________

Patient's or Guardian's Signature: ____

Patient's Name (Please Print): ____