Children's Naturopathic Centre

Sarah McAllister, ND, LC

PATIENT INFORMATION

Patient Name: _____ Age: _____ Date of Birth: _____

SSN: _____ Sex: Male ☐ Female ☐

Address: _____ City/State: _____ Zip: _____

Parent/Guardian: _____ Occupation: _____

Contact Phone: _____ Home ☐ // Work ☐ // Mobile ☐ - Messages OK? Yes ☐ // No ☐

Email: _____ Messages OK? Yes ☐ // No ☐

Parent/Guardian: _____ Occupation: _____

Contact Phone: _____ Home ☐ // Work ☐ // Mobile ☐ - Messages OK? Yes ☐ // No ☐

Email: _____ Messages OK? Yes ☐ // No ☐

Your preferred method of contact: Phone ☐ // Email ☐ (Please note email is not appropriate for urgent questions).

BILLING INFORMATION (if different from above):

Name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

In order for our office to better serve you, please indicate which of the following payment methods you intend to use.

☐ I will self-submit my insurance claim.
☐ I would like Children's Naturopathic Centre to bill insurance; My copay is: _____
☐ I am private pay.

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Contact Phone: _____ Home ☐ // Work ☐ // Mobile ☐ // Alternate Number: _____

If you would like to authorize a partner or other person (not a legal guardian of the child) to discuss your child's health or billing information with us, please list them below.

Name: _____ Relationship: _____

Whom may I thank for this referral? _____

AUTHORIZATION TO TREAT: (*Please initial below*)

_____ I authorize Sarah McAllister, ND to examine and treat my child.

_____ I understand that treatments and therapies recommended by Sarah McAllister, ND may be different than those offered by other licensed health care providers and that I am at liberty to seek other care for my child.

Signature of Guardian:_____ Date: _____

4444 SW Corbett Ave, Portland, OR 97239 // (503)224-2590 phone // (503)224-2592 fax // admin@nd4kids.com