Tahoe Natural Medical Center
Personal Patient Information

Name ____ Today's Date _____________________

Mailing Address ____

City ___________________________________ State _______________ Zip Code ____________________

Phone (cell) ____

Phone (other) ____

Do you receive Texting? ☐ Yes ☐ No Is it ok to communicate to you via E-Mail? ☐ Yes ☐ No

E-mail Address ____

Date of Birth ________________________________ Age __________________ Gender: ☐ M ☐ F

Occupation ___________________________________ Employer ____________________________________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Relationship ☐ Widowed

How did you hear about the clinic? ☐ Brochure ☐ Mountain News ☐ Website ☐ Referral ☐ Other

Who referred you? ____

Emergency Contact Person ____

Phone Number ______________________________ Relationship To You ____________________

Agreement with Payment Policy at Tahoe Natural Medical Center

By signing below, I understand that full payment for all services and products I receive at Tahoe Natural Medical Center is required at the time of service.

Signature ____ Date _____________________