General Information

Date: ____________________

Name:___________________________________ ____ ____/____/____

(Last) (First) (Sex) (Date of birth)

Perm. Address: ______________________________ City: ______________ State: _____ Zip: _________

Phone Perm: _______________ Cell Phone: __________________ Phone Work: _________________

Driver's License #: _____________________ State: ______ Email Address: ______________________

I am willing to support the licensure of Naturopathic Doctors in Ohio. This will entail receiving newsletters from the Ohio Naturopathic Doctors Association (OHNDA) as well as emails when it is time to contact my Legislators to support the bill. Circle one: Yes / No

How did you hear about Toledo Naturopathic?____

Yellow Pages:_________ Newspaper:________ Radio/TV:______ Internet:________ Sign:_______

Were you referred by another health professional?: ☐ Yes ☐ No

Referring Physician's Name: ____________________________________ Phone: ______________________

Address, City, State, Zip: ____

Primary Care Physician: __________________________________ Phone: ______________________

Employer: ___________________________ Occupation:__________________ Phone: ______________

Perm. Address: ______________________________ City: ______________ State: _____ Zip: _________

Nearest relative not living with you: _____________________Relation: ________ Phone:______________

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Name of Spouse (or parent for minor child): _______________________

Emergency Contact: ____________________ Relationship to you: __________ Phone: ________________

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Clinic Policy requires payment at time of services.

__________________________________ __________________________________ ______________

Signature Parent or Guardian's Signature Date

__________________________________ __________________________________

Please Print Name Please Print Name

Toledo Naturopathic, LLC
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