Evergreen Natural Health
1033 Basin Ave. Suite A
Bismarck, ND 58504

Confidential Information

Welcome to Evergreen Natural Health Clinic. We promise to do our best to prove you with the finest care available. If at any time you have

Please take the time to fill out the Questionnaire in order for us to provide you with the best possible care we can!

Name: _____ Preferred name: _____

Address: _____City: _____ State: _____ ZIP: _____

Primary Phone #: _____ Cell Phone # for text reminders: _____

Check here if Primary Phone is a Landline: ☐ (Enter if not Primary Phone)

Email: _____ (Enter email ONLY if you would like to receive EMAIL reminders also)

Date of Birth: _____Age: _____ M or F Marital Status: S M W

Occupation: _____ Whom may we thank for referring you? _____

Medication(s) : _____

_____

Allergies: _____

_____

Present Concerns:_____

_____

_____

Emergency Contact: _____ Phone: _____

Please read the following and sign below:

- I understand the care I receive today is complimentary to my existing healthcare plan. I am responsible for notifying any medical provider about the changes I choose to make.
- I am responsible for paying all appointment fees at the time of service, and $30 for appointments if I fail to cancel at least 24 hours in advance.
- I am aware that Acupuncture, Prolozone, PRP, and IV therapies have a risk of bruising, soreness, pneumothorax, organ puncture and bleeding.
- Evergreen Natural Health Clinic is authorized by law to release or request a patient medical record information to or from healthcare providers (i.e. physician, clinic, hospital, pharmacy, etc.) involved in a patient's care; to release such information as may be necessary or required for statistical reporting or as required by applicable law; to obtain patient medication history information, and to release any medical information necessary to process claims, insurance reviews, preauthorization and case management to any person or corporation which is or may be liable for any part of the claims charges.

Notice of Privacy Practices

I acknowledge that Evergreen Health Clinic has made a copy of its NOTICE OF PRIVACY PRACTICES available to me to read and to keep.

Eve Evergreen Natural Health
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_____ _____

Patient or Authorized Signature Date